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Suicide Risk Assessments: Examining Influences on Clinicians' Professional Judgment

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Professional judgment in complex clinical situations such as the assessment of suicide risk encompasses a multifaceted cognitive understanding of the substantive issues, technical expertise, and emotional awareness. This experimental design study investigated the degree to which the previous work-related experiences of clinicians and their preexisting emotional state influence professional judgment regarding acute risk in patients presenting with suicidal ideation. Experienced social workers and social work students conducted suicide risk assessments on 2 standardized patients performing in scenarios constructed to depict individuals presenting with suicidal ideation. This study revealed significant variations in clinical judgments of practitioners assessing suicide risk. While scores on standardized risk assessment measures were the strongest predictor of judgments regarding the need for hospitalization to ensure the safety of the patient, other influences included clinician age and levels of posttraumatic stress symptoms. Mental health clinicians and organizations that employ them should be aware of possible individual influences on professional judgments related to suicide risk.

In the fall of 2014, the World Health Organization released its first report on suicide entitled “Preventing Suicide: A Global Imperative” (World Health Organization, 2014). The report identifies that suicide takes the lives of 800,000 people each year; that suicides are preventable but require comprehensive, multisectoral strategies; that suicide prevention must be a core element of health care services; and that communities have a critical role to play in suicide prevention. Yet health care and community services are in large part failing in their duties to assess and prevent suicide. Research reveals that the majority of people who take their own lives have contact with health care and mental health professionals shortly before their deaths. For instance, an Australian study using coroner’s data revealed that 79% of people had contact with health care professionals in the 3 months before their deaths by suicide (Draper et al., 2008). A review of 40 studies by Luoma et al.

(2002) determined that on average 45% of suicide victims had contact with health care providers 1 month prior to their deaths and 20% had contact with mental health professionals in the month prior to death. Suicide risk assessment is a critical component of the practice of all mental health practitioners, yet our ability to predict risk remains sadly lacking. This study seeks to better understand clinical decision making in the area of suicide risk.

Scholars have identified that professional judgment in complex clinical situations such as the assessment of suicide risk encompasses a multifaceted cognitive understanding of the substantive issues, technical expertise, and emotional awareness (Epstein, Siegel, & Silberman, 2008; Eraut, 1994; Schön, 1987). Experts reflect on previous experiences and selectively apply this knowledge to the problem at hand (Cheetham & Chivers, 2005; Ruch, 2002), actively using critical thinking and tacit knowledge to find creative solutions (Cheetham & Chivers, 1998; Eraut, 2002; Schön, 1983, 1987). Indeed, despite a recent emphasis on evidence-based practice (Regehr, Stern, & Shlonsky, 2007), professionals continue to rely primarily on tacit knowledge consisting of their own experience, professional values and consultations with colleagues (McLaughlin, Rothery, Babins-Wagner, & Schleifer, 2010). However, in the area of suicide risk, expertise alone has been proven to be a remarkably inaccurate predictor. A study examining professional judgments of suicide risk determined that participating psychiatrists and nurses had ratings of risk that ranged from 25–100% for a single case scenario. Also concerning in this study was that 42% of psychiatrists and 78% of nurses had

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significantly different ratings of risk on the same case scenario at different time periods (Paterson et al., 2008).

In all forms of risk assessment, controversy exists regarding the relative value of clinical assessments based on expertise and standardized, evidence-based risk assessment measures based on actuarial data (Camasso & Jagannathan, 2000; Glancy & Regehr, 2004; Lyons, Doueck, & Wodarski, 1996; Shlonsky & Wagner, 2005; Sreenivasan, Kirkish, Garrick, Weinberger, & Phenix, 2000; Zonana, 1999). A range of studies have compared a variety of risk assessment scales to clinical assessments of clients with suicidal ideation (Bisconer & Gross, 2007; Cochrane-Brink, Lofchy, & Sakinofsky, 2000). However, while scales are important adjuncts to clinical assessment, no scale reliably predicts whether clients will ultimately die of suicide (Harriss & Hawton, 2005). Suicide risk assessment must take into account unique and distinctive patient risk and protective factors for which no evidence base exists (Simon, 2006). Consequently, clinical judgment remains a critical component of any assessment of suicide risk, even when augmented with actuarial tools.

The present study hypothesized that differences in professional judgment occur as a result of the interaction between clinician factors and context factors. One set of factors may involve previous professional experiences, such as traumatic exposures in the course of mental health practice that may potentially affect performance and judgment with respect to suicide risk. For instance, surveys suggest that approximately 1/4 to 1/3 of social workers report being assaulted at some time in their careers and approximately 1/2 to 3/4 have been threatened with physical harm (Macdonald & Sirotich, 2001, 2005; Newhill, 1995; Regehr, Hemsworth, Leslie, Howe, & Chau, 2004; Rey, 1996). Victimization in the workplace has profound effects on workers, negatively affecting performance (Mahoney, 1991).

A second form of trauma exposure in mental health professionals relates to working with highly distressed individuals. Several quantitative studies point to elevated rates of trauma symptoms in practitioners providing services to traumatized individuals (Arvay & Uhlemann, 1996; Bober & Regehr, 2006; Brady, Guy, Poelstra, & Brokaw, 1999; Gates & Gillespie, 2008; Ortlepp & Friedman, 2002; Schauben & Frazier, 1995). In addition, losing a patient to suicide is an experience many clinicians share (Palmieri et al., 2008; Ting, Jacobson, & Sanders, 2008). Indeed, 33% of mental health social workers report having lost a patient to suicide (Sanders, Jacobson, & Ting, 2008). This experience has been found to undermine a sense of professional competence, cause acute stress and grief reactions, and lead to burnout (Gaffney et al., 2009; Linke, Wojciak, & Day, 2002).

Job burnout is now one of the most frequently studied concepts in organizational and employment research in all occupational domains (Acker, 1999; Lloyd, King, & Chenoweth, 2002; Swider & Zimmerman, 2010; Van Hook & Rothenberg, 2009). Burnout is a multidimensional construct involving emotional exhaustion, depersonalization and personal accomplishment (Maslach & Jackson, 1981). Burnout has been linked to absenteeism, job turnover (Swider & Zimmerman, 2010; Travis, Lizano, & Mor Barak, 2015), and lower levels of perceived competence (Acker & Lawrence, 2009). It is interesting, however, that the association between burnout and job performance is less conclusive (J. Beck, Gerber, Brand, Pühse, & Holsboer-Trachsler, 2013), with some research suggesting it is unequivocally associated with poorer

performance (Diestel, Cosmar, & Schmidt, 2013) and other research suggesting the association is weak at best (Demerouti, Bakker, & Leiter, 2014).

Given that suicide risk assessment is a frequent and high stakes component in the provision of mental health care, it is critical that we better understand elements of professional decision making to improve patient safety. This experimental design study investigated the degree to which the previous work-related experiences of social workers and their preexisting emotional state including symptoms of stress, posttraumatic stress, and burnout influence professional judgment regarding acute risk in patients presenting with suicidal ideation.

Method

This experimental design study utilized standardized patients performing in scenarios constructed to depict individuals presenting with suicidal ideation. The research protocol was approved by the Research with Human Subjects Ethics Board of the University of Toronto and the project was funded by the Social Sciences and Humanities Research Council of Canada. Written consent was obtained from all participants.

Seventy-one people participated in this study, 37 final-year Master of Social Work (MSW) at the University of Toronto students who were specializing in mental health (52.1%) and 34 experienced social workers primarily employed in inpatient and outpatient departments of large mental health facilities in three different cities (47.9%). Eighty-two percent of the participants were women, which is consistent with the overall gender distribution of social workers (Regehr, 2013). The age range of participants was 21 to 78. The mean age of experienced social workers was 42.50 (*SD* 13.56) and the mean age of MSW students was 27.43 (*SD* 5.29). The experienced social workers were more likely to be married or in a common-law relationship (64.7%) than students (32.4%). Experienced social workers had a mean of 12.90 years of experience (*SD* 12.40), MSW students had a mean of 0.61 years of experience (*SD* 1.79). In terms of level of education, 94.1% (32) of the experienced social workers had an MSW, one person had a BSW and one had a PhD. One of the MSW students had a PhD in another field, 41.70% had a university degree in another field and 50.0% had a BSW prior to entering their current program.

Baseline Measures

Participants completed a series of questionnaires aimed at understanding their previous history of traumatic exposure in the workplace, and current emotional state including current level of symptoms of traumatic stress and burnout. Demographic information was obtained through a short questionnaire assessing age, gender, marital status, years of experience, professional education and training, and prior exposure to traumatic events in the workplace.

Trauma symptoms were assessed by the Impact of Event Scale-Revised (IES-R; Weiss & Marmar, 1997), which assesses post-traumatic stress symptoms for any specific life event. The severe range has been found in other studies to have symptoms at a level equivalent to a diagnosis of PTSD. Scores on this scale have high

internal consistency (Cronbach's $\alpha \geq .86$) and test-retest reliability of .87.

Burnout was measured using the Maslach Burnout Inventory (MBI; Maslach & Jackson, 1981), which assesses three components of burnout, emotional exhaustion, depersonalization, and lack of personal accomplishment. This scale has been used by over 90% of reported studies on burnout and has excellent reported reliability and validity of scores in a variety of populations (Schaufeli, Bakker, Hoogduin, Schaap, & Kladler, 2001).

Stress was measured by the Perceived Stress Scale-10 (PSS-10), which is a 10-item scale addressing three components of stressful experiences: unpredictability, uncontrollability, and overloading (Cohen & Williamson, 1988). Alpha coefficients in a sample of 285 college students ranged from .82 to .89. Reported mean scores in the college student sample were 17.4 (*SD* 6.1) for men and 18.4 (*SD* 6.5) for women; this difference was not statistically significant (Roberti, Harrington, & Storch, 2006).

Simulated Suicide Risk Assessment

Participants were asked to assess two simulated patients, portrayed by standardized patients, presenting with suicidal ideation. Through random assignment, half the participants interviewed one client first and the other half interviewed the other client first to control for order effects. Workers were required to interact with the standardized patient, gather information through a clinical interview, and make a determination of suicide risk.

The Standardized Patient Program at the University of Toronto was established 25 years ago following the model developed in the 1960s by Barrows. The use of standardized patients ensures consistency in patient presentation allowing for comprehensive assessment of clinical competence (Barrows, 1993). Standardized patients are healthy individuals trained to portray the personal history, physical symptoms, emotional characteristics, and everyday concerns of actual patients. While they are trained to give consistent information and maintain a consistent level of emotional intensity and engagement, the nature and quantity of information they provide is dependent on the questions posed by the interviewer.

Each scenario was of 15 min duration and recreated a credible client encounter. One client was an adolescent/young adult (Karolina) presenting with a situational crisis, and the second was a depressed middle-aged woman (Margaret), who is a victim of intimate partner violence. The scenarios were pilot tested with a cross-section of social workers to ensure that they were experienced as realistic client encounters. Researchers have previously demonstrated that this type of design can successfully replicate stressful workplace encounters in studies with child welfare workers (Regehr, LeBlanc, Shlonsky, & Bogo, 2010), paramedics (LeBlanc et al., 2012), medical residents (Harvey, Bandiera, Nathens, & LeBlanc, 2012), and police officers (LeBlanc, Regehr, Jelley, & Barath, 2008; Regehr, LeBlanc, Jelley, & Barath, 2008).

Appraisal of Suicide Risk

At the end of each scenario, participants were asked to determine whether or not the client required hospitalization because of imminent risk of suicide. Participants then completed three standardized suicide

risk assessment measures, the Beck Scale for Suicide Ideation, the Hamilton Rating Scale for Depression, and the Columbia-Suicide Severity Rating Scale. Thus, the standardized measures were not used as clinical guides in this study but were rather used to assess factors that workers included in their judgment.

The Beck Scale for Suicidal Ideation (BSS) is a 21-item scale designed to assess a person's thoughts, plan, and intent to commit suicide (A. Beck & Steer, 1991). Studies comparing risk assessment scales to clinical assessments of clients with suicidal ideation have suggested the BSS has greatest accuracy (Cochrane-Brink et al., 2000).

The Hamilton Rating Scale (HRS) for Depression (Hamilton, 1960) is the most widely used clinician-administered measure of depression. The scale has shown good indications of valid and reliable scores in a variety of populations with internal reliability and interrater reliability ranging from 0.82–0.98; test-retest reliability ranges from 0.81–0.98 (Bagby, Ryder, Schuller, & Marshall, 2004).

The Columbia-Suicide Severity Rating Scale (C-SSRC) quantifies four aspects of suicide risk: severity of ideation, intensity of ideation, previous suicidal behavior, and lethality of attempts. Scores on the scale have been demonstrated to have good convergent and divergent validity with scores on other suicide scales as well as good predictive validity and sensitivity to change (Posner et al., 2011).

Results

Prior Exposure to Workplace Trauma and Symptoms of Distress

Respondents were asked to indicate whether they had encountered any of a list of events and whether they experienced "emotional distress" as a result of exposure to the event(s). Thirty-one percent of participants indicated that they had worked with a patient who committed suicide (52.9% of experienced workers and 10.8% of students); 20% had been assaulted by a patient; 47.1% had been threatened with violence; 65.7% had colleagues that had been threatened by a patient; and 23.9% worked with patients who had inflicted severe injuries on others. A total of 73.2% of respondents indicated that they had experienced at least one work-related critical incident (82.4% of experienced workers and 64.9% of students). Of those who did experience a work-related incident, 53.8% indicated that they experienced emotional distress as a result of the exposure (60.1% of exposed workers and 45.8% of exposed MSW students). These high rates of reported exposure to critical events are consistent with previous research on child welfare workers (Regehr et al., 2010; Regehr, Leslie, Howe, & Chau, 2005).

T test analyses were conducted to examine possible differences between experienced social workers and students on the standardized measures. Although students reported higher levels of symptoms, there was no significant difference between the scores of experienced social workers and students on the measures of stress, burnout, or posttraumatic stress. As a result, samples were combined in further analyses.

Scores on the Perceived Stress Scale were significantly lower ($t = 3.63, p \leq .001$) in the present study group than reported means for college students (Roberti et al., 2006). With respect to burnout, scores on the personal accomplishment scale of the Maslach's Burnout were significantly less favorable in this sample

than in samples of registered nurses ($t = 7.96, p \leq .001$) and when compared to published norms ($t = 7.77, p \leq .001$). However, the present group reported less emotional exhaustion than registered nurses ($t = 6.84, p \leq .001$) and published norms ($t = 12.81, p \leq .001$). Scores on the depersonalization scale were not significantly different than published norms (Beckstead, 2002; see Table 1).

Twenty-five individuals (35.2%) scored in the high or severe range of the IES-R scale. Of these, 16 (22.5%) fell in the severe range, which is considered consistent with a clinical picture of PTSD. Scores on the Impact of Event Scale were not significantly different than those reported in studies of social workers in child welfare settings (Regehr et al., 2004).

Assessment of Risk

There was considerable variability in participants' assessment of suicidal risk for the two simulated patients. Seventy percent of participants believed that the adolescent patient in acute crisis (Karolina) did not require hospitalization as a result of suicide risk, while 30% believed that she should be hospitalized. Similarly, 62.9% of participants believed that the depressed middle-aged woman (Margaret) should be hospitalized whereas 37.1% believed she did not require hospitalization. MSW students were significantly less likely to believe that Karolina required hospitalization ($\phi = -0.318, p \leq .01$). There was no significant association between believing that Karolina required hospitalization and believing that Margaret required hospitalization. Further, there was no significant association with previously encountering a patient suicide and judgment regarding the need for hospitalization.

Professional judgment that Karolina should be hospitalized versus not hospitalized was associated with four factors in T test analyses: the age of the respondent ($t = -2.75, p \leq .001$), scores on the Beck Suicide Scale ($t = 5.45, p \leq .001$), scores on the Hamilton Rating Scale for Depression ($t = -2.72, p \leq .01$), and scores on the Columbia-Suicide Severity Rating Scale ($t = 2.95, t \leq 0.01$) (see Table 2). That is, in addition to the association between scores on the suicide scales and judgment that hospitalization was necessary, younger respondents were less likely to believe that the adolescent patient required hospitalization. Logistic regression analysis revealed that only two factors were significantly associated with the judgment that Karolina required hospitalization when the influence of other factors was taken into account: the BSS, which independently accounted for 47% of the

Table 2. Correlational Matrix Between Measures of Personal Distress and Risk Assessment Tools for Karolina

	BSS	HRS	C-SSRS	PSS	IES-R	MBI-PA	MBI-EE	MBI-D
BSS	1	.57**	.57**	-.06	-.11	.08	.10	.07
HRS		1	.35**	.15	.00	.00	.10	.11
C-SSRS			1	-.13	-.32**	.19	.14	.02
PSS				1	.52**	-.44**	.43**	.27*
IES-R					1	-.25*	.26*	.30*
MBI-PA						1	-.53**	-.54**
MBI-EE							1	.60**

Note. BSS = Beck Scale for Suicidal Ideation; HRS = Hamilton Rating Scale; C-SSRS = Columbia-Suicide Severity Rating Scale; PSS = Perceived Stress Scale; IES-R = Impact of Event Scale-Revised; MBI = Maslach's Burnout Inventory.

* $p \leq .01$. ** $p \leq .001$.

variance ($\beta = .24, p \leq .001$), and age of respondent, which accounted for an additional 8% of the variance ($\beta = .06, p \leq .05$).

Professional judgment that Margaret should be hospitalized was associated with only one factor in T test analyses: scores on the Beck Suicide Scale ($t = -3.50, p \leq .001$) (see Table 3). That is, higher scores on the BSS were associated with a judgment that hospitalization was necessary. In a logistic regression analysis, the BSS accounted for 24% of the variance ($\beta = 0.13, p \leq .05$).

The three measures of patient risk—the Beck Suicide Scale, the Hamilton Rating Scale for Depression, and the Columbia-Suicide Severity Rating Scale—were significantly associated with one another in correlational analyses ($r = 0.41$ to $r = .52, p \leq .001$). In addition, however, scores on the Impact of Event Scale were significantly negatively associated with scores on the BSS ($r = -0.24, p \leq .05$), and C-SSRS ($r = -0.25, p \leq .05$) for Margaret and with the C-SSRS for Karolina ($r = -0.32, p \leq .01$). That is, individuals with higher levels of posttraumatic stress symptoms rated patients as at lower risk of suicide. There was no significant association between measures of patient risk and worker burnout (MBI) or perceived stress (PSS).

Discussion

The present study used an experimental design to simulate lifelike clinical situations involving patients with potential suicide

Table 1. Scores on Measures of Personal Distress

Variable	Mean score for experienced workers	Mean score for students	Mean score for total sample
Maslach's Burnout Inventory			
Personal accomplishment	30.47 (SD 5.03)	28.29 (SD 5.27)	29.65 (SD 5.18)
Emotional exhaustion	12.23 (SD 7.97)	13.78 (SD 5.68)	13.03 (SD 6.88)
Depersonalization	7.12 (SD 6.80)	6.19 (SD 4.75)	6.63 (SD 5.80)
Perceived Stress Scale	14.30 (SD 5.35)	16.14 (SD 6.02)	15.27 (SD 5.75)
Impact of Event Scale			
Intrusion	6.24 (SD 5.36)	7.65 (SD 6.53)	6.97 (SD 6.00)
Arousal	2.18 (SD 2.24)	3.78 (SD 4.45)	3.01 (SD 3.64)
Avoidance	4.47 (SD 4.88)	6.43 (6.14)	5.49 (SD 5.62)
Total	12.88 (10.56)	17.86 (SD 15.85)	15.48 (SD 13.72)

Table 3. *Correlational Matrix Between Measures of Personal Distress and Risk Assessment Tools for Margaret*

	BSS	HRS	C-SSRS	PSS	IES-R	MBI-PA	MBI-EE	MBI-D
BSS	1	.41**	.54**	.09	-.24*	.14	-.23	-.02
HRS		1	.45**	.02	-.11	.18	.08	.00
C-SSRS			1	-.01	-.25*	.16	.08	-.09
PSS				1	.52**	-.44**	.43**	.27*
IES-R					1	-.25*	.26*	.30*
MBI-PA						1	-.53**	-.54**
MBI-EE							1	.60**

Note. BSS = Beck Scale for Suicidal Ideation; HRS = Hamilton Rating Scale; C-SSRS = Columbia-Suicide Severity Rating Scale; PSS = Perceived Stress Scale; IES-R = Impact of Event Scale-Revised; MBI = Maslach's Burnout Inventory.

* $p \leq .01$. ** $p \leq .001$.

risk. Results revealed considerable variability in clinical decision making, with approximately one third of participants judging that the adolescent should be hospitalized and two thirds judging that the chronically depressed woman should be hospitalized. This variability is consistent with that found in previous research (Patterson et al., 2008). The strongest predictors of clinical judgment regarding the need for hospitalization were scores on the Beck Suicide Scale and Columbia-Suicide Severity Rating Scale, suggesting that these measures are predictive of clinical decision making. This is heartening and demonstrates that clinical decision making was primarily based on well-known clinical indicators.

Nevertheless, some personal factors were associated with clinical decision making, specifically age of the social worker and level of posttraumatic stress symptoms. In the case of Karolina, the adolescent in crisis, younger workers were significantly less likely to view that she required hospitalization. It would seem that workers closer in age to this patient were more likely to contextualize situational distress of an adolescent and see it as within the realm of normative behavior that would resolve without hospital intervention.

In both simulated clinical cases, higher levels of posttraumatic stress in the social workers as measured by scores on the Impact of Event Scale-Revised were associated with lower assessed suicide risk as measured by scores on the Beck Suicide Scale for the chronically depressed patient, and lower scores on the Columbia-Suicide Severity Rating Scale for both patients. This finding replicates that of an earlier study with child welfare social workers in which increased levels of posttraumatic symptoms reduced the likelihood that a worker would determine that a child was at risk of abuse (Regehr et al., 2010).

Researchers have found that individuals' subjective emotions shape cognitive processes including perception, attention, and memory. Emotional arousal narrows and focuses attention, reducing the number of cues to which the individual attends (LeBlanc, McConnell, & Monteiro, 2015). Studies of clinical decision making have found that individuals in more positive mood states are more thorough in their clinical investigations, considering a wider range of diagnoses and treatments, while individuals with negative mood states are not only less likely to consider a wide range of information, but they are also more likely to take risks (LeBlanc et al., 2015). As previous investigations have focused on current and potentially transient emotional reactions, longer term states such as

PTSD may have particular effects on clinical decision making that should be explored further. In the case of the present study, it is possible that workers with higher levels of traumatic stress symptoms were less likely to ask questions that would elicit information about suicidal thoughts from patients or less likely to attend to clinical cues, and therefore made assumptions that risk is lower. It is also possible that they had higher risk tolerance.

On the other hand, burnout was not associated with assessment of suicide risk in this study. Previous research has suggested that burnout is associated with impairments of executive functioning, defined as the ability to regulate cognitive functioning to manage novel and challenging situations (Diestel et al., 2013). This would seem to be a significant risk in such complex tasks as evaluating suicide risk. However, cognitive deficits have been found to be related primarily to the emotional exhaustion component of burnout, which was a less significant problem in the present study population than in other reported samples, including normative populations (Beckstead, 2002). Further, where emotional exhaustion is in evidence, studies suggest that sufficiently aware individuals can overcome the negative effects on cognitive functioning through compensatory behaviors (J. Beck et al., 2013; Demerouti et al., 2014).

Limitations

This study has a number of limitations that may influence the findings. In the first place, the study has relied on lifelike clinical situations that may not accurately reflect real-life clinical encounters. Further, given the time constraints of the study, clinical interviews were abbreviated to 15 min and other information that may have been collected in a lengthier interview may not have been available to workers. Nevertheless, despite the limited time-frame, many workers were able to confidently come to a conclusion regarding the client's level of risk. This is consistent with decision-making theory and research in which clinicians have been found to form judgments early in the assessment process that are then confirmed by selective attention to subsequent information (Arkes, 1981; Baumann, Deber, & Thompson, 1991; Gambrill & Shlonsky, 2000; Smith & Dumont, 2002). In this way, previous experiences sway current judgments.

Conclusions

This study revealed significant variations in clinical judgments of social workers assessing suicide risk. While scores on standardized risk assessment measures were the strongest predictor of judgments regarding the need for hospitalization to ensure the safety of the patient, other influences included clinician age and levels of posttraumatic stress symptoms. These findings have important implications for the assessment of suicide risk by clinicians. First, it is imperative that clinicians are aware that judgments may be influenced by personal factors and appropriately seek consultation on important decisions related to suicide risk. Second, organizations responsible for mental health services need to ensure that supports are in place for workers who encounter traumatic events in the course of their practice, and that these supports should include education regarding the possible impact of traumatic stress reactions on their work. Finally, it is vital that continued research be conducted on reliability and validity

of risk assessment measures in clinical situations to more fully understand worker factors that may influence their use of standardized measures.

Keywords: stress; burnout; trauma; suicide; risk assessment

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An Exploratory Study of Nonsuicidal Self-Injury and Suicidal Behaviors in Adolescent Latinas

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To date, there is little research to validate empirically differences between nonsuicidal self-injurious behavior (NSSI) and attempted suicide among Latina adolescents. Understanding the characteristics and contextual features of self-harmful behaviors among Latina teens is a critical public health and social justice matter given the disproportionate rates of attempted suicide and anticipated population growth of this vulnerable group. In this article, we draw on an ecodevelopmental model to focus attention on factors in the sociocultural environment that shape suicidal behaviors and NSSIs. Through analysis of qualitative interviews conducted with girls who used NSSI ($n = 18$), attempted suicide ($n = 29$), used NSSI and attempted suicide ($n = 8$), and had no reported lifetime history of self-harm ($n = 28$), we describe the sociocultural factors that shaped psychosocial vulnerabilities and gave rise to decisions to use NSSI or attempt suicide. Our analysis revealed that adolescents who engaged in NSSI perceived their negative feelings as something that could be controlled through self-injurious acts, whereas powerlessness was a theme underlying the emotional states of girls who attempted suicide. When NSSI ceased to function as a mechanism for control, girls came to sudden decisions to attempt suicide. Most teens identified specific, and often multiple, situations that induced intense affective states and shaped decisions to inflict self-harm. Two situational experiences emerged as particularly salient and promising for subsequent studies on self-harmful behaviors among Latina adolescents: transnational stress and bullying. We describe each of these and offer suggestions for future research and practice.

For the past 20 years, Latina adolescents have reported elevated rates of attempted suicide compared with non-Hispanic White and African American adolescents (Centers for Disease Prevention and Control, 2014; Romero, Edwards, Bauman, & Ritter, 2014).¹ Although suicidal behaviors among Latina teens have been well documented in the literature, nonsuicidal self-injury (NSSI) has received little attention. A growing body of research focuses on variations in the psychological and social profiles that give rise to self-harming behaviors in adolescents, but few studies have included Latina participants (Croyle,

2007; Gutierrez, Rodriguez, & Garcia, 2001; Hilt, Cha, & Nolen-Hoeksema, 2008; Lipschitz et al., 1999; Sandoval, 2006).² Given the recent recommendation in the DSM-5 for increased research on NSSI and suicidal behaviors as distinct, rather than overlapping, syndromes (American Psychiatric Association, 2013), there is a need to investigate the similarities and differences between these two behaviors across racial and ethnic groups (Kim et al., 2014). This article represents a first step toward understanding the contexts within which Latina teens use NSSI and/or attempt suicide. Our purpose is not to provide definitive conclusions that can be generalized, but rather to open the door for a critical discussion about self-harmful behaviors within adolescent Latina populations.

Given the lack of information on similarities and differences between suicidal behaviors and NSSIs within diverse populations (Hamza, Stewart, & Willoughby, 2012), we begin with an examination of the challenges associated with distinguishing NSSI from attempted suicide. We then use studies of attempted suicide by Latina teens as a starting point to outline potential factors that shape decisions to engage in self-harmful behaviors. We highlight the potential

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¹We use the word “Latina” to refer to participants who self-identified as Hispanic and living in the United States.

²Following Muehlenkamp (2014), we use the phrase “self-harming behaviors” to reference both suicidal behaviors and NSSIs.

for an ecodevelopmental approach to contextualize Latina teens' decisions to use NSSI and/or attempt suicide, and we draw on this approach to frame our exploratory qualitative study of Latina teens with and without histories of NSSI and/or attempted suicide.

The Challenge in Distinguishing NSSI From Attempted Suicide

For many researchers and clinicians, the intent of NSSI is a key distinguishing factor. NSSI is often defined as self-harm without the intent to die (Muehlenkamp, 2005; Nock & Prinstein, 2004), and most evidence to date suggests that the majority of teens self-injure as a strategy to alleviate acute emotional distress (Chapman, Gratz, & Brown, 2006; Klonsky & Muehlenkamp, 2007; Nock & Prinstein, 2004; Yip, 2005). In contrast, a suicide attempt is classified as a nonfatal, self-inflicted destructive act with the explicit or implied intent to die (Goldsmith, Pellmar, Kleinman, & Bunney, 2002). Despite the seemingly clear-cut differences between NSSI and attempted suicide on the basis of intent, differentiating the two behaviors in the context of research and practice proves to be challenging. For example, the data analyzed in this article came from a larger study in which mental health practitioners originally assessed all participants as suicidal. It was only in the context of an in-depth, qualitative interview that many participants reported not having any intention to kill themselves (Zayas, Gulbas, Fedoravicius, & Cabassa, 2010).

Distinguishing NSSI from a suicide attempt is often difficult, in part, because the two behaviors exhibit numerous similarities in terms of risk factors. Childhood trauma and abuse (Baetens, Claes, Muehlenkamp, Grietens, & Onghena, 2011; Boxer, 2010), family conflict (Wong, Stewart, Ho, & Lam, 2007), and negative peer interactions (Muehlenkamp, 2014) have all been shown to be associated with suicide attempts and NSSI, although adolescents who attempt suicide report greater exposure to stressful life events (Andover, Morris, Wren, & Bruzzese, 2012). In addition, individuals who engage in NSSI or suicidal behavior exhibit higher levels of physiological reactivity in response to stress, a reduced ability to tolerate stress, and concurrent deficits in social problem-solving abilities compared with those without a lifetime history of suicidal or NSSIs (Donaldson, Spirito, & Farnett 2000; Goldston et al., 2001; Nock & Mendes, 2008).

Efforts to differentiate NSSI from attempted suicide are further challenged by extensive overlap in terms of lifetime history of the two behaviors. Studies have demonstrated that individuals often engage in both NSSI and attempted suicide over the course of their lifetimes (Muehlenkamp & Gutierrez, 2004). For example, Nock et al. (2006) found that up to 55% of adolescents who reported nonsuicidal self-injuries also attempted suicide, sometimes repeatedly. This research has motivated continued interest in understanding potential associations between NSSI and future suicidal behavior (Taliaferro, Muehlenkamp, Borowsky, McMorris, & Kugler, 2012).

Self-Harmful Behaviors in Latina Teens

Latina teens are a growing population at heightened risk for engaging in acts of self-harm (Croyle, 2007). The Latino population has grown 43% within the past decade, accounting for more than 50% of the population growth within the United States between 2000 and 2010 (Passel, Cohn, & Lopez, 2011). Moreover, NSSI and suicidal

behaviors often onset during adolescence (Nock et al., 2008). Among Latina teens, the 12-month prevalence of attempted suicide is 15.6% (Centers for Disease Prevention and Control, 2014). The prevalence rate of NSSI among Latina teens is understudied, but in general, adolescents have been shown to be at increased risk for engaging in NSSI compared with adults (Nock & Prinstein, 2005), with lifetime rates ranging up to 56% in some nonclinical community populations (Cerutti, Manca, Presaghi, & Gratz, 2011).

Despite limited research on NSSI among Latina teens, studies on suicidal behaviors can provide a foundation for identifying potential factors that shape decisions to engage in NSSI (Croyle, 2007). In the literature on Latina teens' suicide attempts, research consistently demonstrates that stressed relations between attempters and their parents seem to be a common factor (Zayas et al., 2010; Duarté-Vélez & Bernal, 2007; Flouri & Buchanan, 2002; Johnson et al., 2002). Family relationships of the attempter have been characterized as tense or weak, stemming from poor communication, mentoring, and/or support (Zayas et al., 2010; Zayas & Gulbas, 2012; Garcia, Skay, Sieving, Naughton, & Bearinger, 2008; Razin et al., 1991). Differences in perceptions of parenting style, respectful behavior, adolescent autonomy, and the allocation of household rules and responsibilities have not only been shown to contribute to conflict (Bronstein, 1994; Cardona, Nicholson, & Fox, 2000; Halgunseth, Ispa, & Rudy, 2006; Szapocznik & Williams, 2000), but to act as the triggering event that precedes a suicide attempt (Zayas et al., 2010; Zayas & Gulbas, 2012). In its most extreme form, family conflict can engender violence, and many Latina teens decide to attempt suicide in the wake of violent family trauma (Zayas et al., 2010; McFarlane, Groff, O'Brien, & Watson 2003).

By focusing attention on family dynamics, this literature has helped to elucidate links between culture and Latina teen suicidal behavior. Family conflict can be especially burdensome to Latina adolescents because it contradicts salient cultural values that posit the family as a cohesive, harmonious, interdependent social unit (Romero et al., 2014). Put another way, Latino families often espouse a value orientation that is "household-centered rather than child-centered" (Villenas & Dehyl, 1999, p. 424). Yet, the capacity to uphold this cultural value is context-dependent. When Latino families endure stressors, such as underemployment, discrimination, or fragmented social structures, parents and adolescents sometimes find themselves unable or unwilling to provide family support (Zayas & Gulbas, 2012; Guarnaccia, Parra, Deschamps, Milstein, & Argiles, 1992). Using this cultural framework, attempted suicide by Latina teens can be understood as an act that speaks not only to the psychosocial state of the individual, but also of the family: Individual distress is a family affair, whereas family suffering is deeply felt at the individual level (Zayas & Gulbas, 2012). The question remains: Do similar individual, family, and sociocultural processes shape the use of NSSI among Latina teens? We assert that an ecodevelopmental framework presents a productive starting point to addressing this question.

An Ecodevelopmental Approach to Self-Harmful Behaviors

To frame our understanding of self-harmful behaviors among Latina teens, we draw on an ecodevelopmental framework to highlight the proximal factors that give rise to self-harmful behaviors within a specific sociocultural context (Zayas, Lester, Cabassa, &

Fortuna, 2005; Bronfenbrenner, 1979; Coatsworth et al., 2002; Szapocznik & Coatsworth, 1999). An ecodevelopmental approach focuses attention on the various ways in which adolescents—and all individuals—engage their surroundings through different levels of interaction. In the microsystem, which is the focus of this article, adolescents have direct contact with their surrounding environment through their relationships with family members, peers, schools, and communities. The mesosystem refers to links between the different microsystems encountered by adolescents; for example, interactions between parents and teachers. The exosystem includes those aspects of the environment that indirectly shape an individual's microsystem, such as place of residence. Finally, the macrosystem references the ideological underpinnings of a group or society that shape and are shaped by micro-, meso-, and exosystems (Coatsworth et al., 2002; Korbin, 2013).

In the study of self-harmful behaviors among Latina adolescents, an ecodevelopmental approach promotes a shift from strictly individual or psychological variables to consider the links between an adolescent and the context of her daily life. The framework focuses attention on factors in the sociocultural environment that shape an adolescent's emotional and psychosocial vulnerabilities and give rise to harmful behaviors. To date, this conceptual model has been influential in understanding Latina teen suicide attempts, illustrating how family conflict (Zayas et al., 2010; Zayas & Gulbas, 2012; Fortuna, Perez, Canino, Sribney, & Alegría, 2007; Garcia, Skay, Sieving, Naughton, & Bearinger, 2008), racial and ethnic discrimination (Romero, Wiggs, Valencia, & Bauman, 2013), and immigration-related traumas (Goldston et al., 2008; Cervantes, Goldbach, Varela, & Santisteban, 2014) play a role in decisions to attempt suicide.

Few studies have utilized an ecodevelopmental approach to distinguish NSSI and attempted suicide. It is the aim of this article to describe and compare the conditions and experiences that precede the decision to self-harm to contribute to an understanding of the contexts surrounding self-harmful behaviors within Latina adolescent populations. In this exploratory study, we analyze in-depth qualitative interviews conducted with Latina teens who used NSSI and/or attempted suicide. We also include interviews with Latina teens who had no report of suicidal behaviors or NSSIs to contextualize normative social processes and ecological contexts that are shared among Latina adolescents sampled within this study. We direct specific attention to themes of emotional vulnerability, family context, and broader sociocultural environment to identify potential factors that shaped adolescents' decisions to engage in acts of self-harm and distinguish NSSI from attempted suicide.

Method

For this report, we draw on data from a large federally funded, mixed-method project conducted between 2005 and 2010 that examined the interplay between sociocultural processes and suicidal behavior among young Latinas living in low-income households in New York City (see Kuhlberg, Peña, & Zayas, 2010; Zayas et al., 2005). Adolescents with no lifetime history of suicidal behavior were also included to examine why some Latina adolescents attempt suicide compared with others who share similar developmental, social, and demographic characteristics, including country of origin, place of residence, socioeconomic status, family structure (single-parent or dual-parent household), and levels of

acculturation. A total number of 139 adolescents were recruited for participation in the qualitative phase of the larger study, including 73 Latinas between the ages of 11 and 19 who engaged in acts of self-harm within 6 months preceding the interview and a comparison group of 66 Latina adolescents with no reported lifetime history of self-harm.³

Participants who self-harmed were recruited from a municipal hospital with psychiatric emergency and outpatient departments, a private psychiatric hospital, and mental health services associated with an agency that served a large Latino population. Participants with no history of self-harm were recruited from primary care medical clinics and local community agencies that provided after-school, prevention, and/or youth development programs. Exclusionary criteria for participation among all participants in the study included diagnosis of schizophrenia, psychotic disorders, bipolar disorder, or cognitive disability. Among all participants, girls and their parents gave assent and consent for participation in the study.

Procedures for recruiting and obtaining informed consent proceeded as follows. First, agency intake supervisors and community agency liaisons identified potential participants. For the purposes of recruitment, participants with a history of self-harm were identified by mental health clinicians who assessed their behavior as suicidal based on their professional and clinical judgment. The degree of lethality was not used as an exclusionary criterion because suicidal behaviors among Latina adolescents exhibit low lethality (Turner, Kaplan, Zayas, & Ross, 2002; Berne, 1983; Razin et al., 1991; Trautman, 1961). Then, agency staff discussed the study with both the adolescent and parents. At this stage, families with an adolescent with no lifetime history of self-harm who expressed interest were referred to the research team, who contacted the girl and parents for assent and consent. When adolescents who engaged in acts of self-harm and their parents expressed interest, a staff member informed the parents that the girl's therapist would need to grant approval to participate. With parental agreement, the adolescent was assessed for her readiness to participate by her therapist. All agency staff and therapists emphasized the volunteer nature of participation to prevent adolescents from feeling coerced. Following approval, the therapist referred the adolescent and her parents to the research team for assent and consent.

After the completion of informed consent procedures, researchers scheduled interview appointments. Approximately 95% of adolescent interviews occurred the same day that consent was granted. Of those participants approached for participation in the study, nearly 90% agreed to participate (see Zayas, Hausmann-Stabile, & Pilat, 2009). All respective institutions

³In this article, we define adolescence as particular moment in an individual's lifespan that is marked by (a) a liminal positioning between childhood and adulthood and (b) the growing importance of peers within the ecological context (Schlegel & Hewlett, 2011). Such a definition promotes a contextual understanding of development rather than one predicated on an age-based model. As cross-cultural studies have demonstrated (Arnett, 2014; Johnson, Crosnoe, & Elder, 2011; Korbin, 2013; Schlegel & Hewlett, 2011), the timing and duration of adolescence varies considerably. By adopting a broad definition of adolescence as "the second decade of life" (Johnson et al., 2011), we move beyond a traditional framework of adolescent development that has been largely informed by research conducted in the United States with middle-class, White children (McLoyd, 1998).

where research activities were undertaken granted institutional review board approval.

Participants

In this article, we present data drawn from a subsample of participants in the larger study. Among participants with a history of self-harm, we incorporate only those individuals who explicitly stated in the qualitative interview the intent of their actions. To select the subsample, we read each interview transcript of the 73 Latina youth who self-harmed to determine how the participant defined her behavior according to her answer to the following interview question: "At the time, what was the intent of your action?" Based on the answer, we distinguished NSSI from a suicide attempt according to the meanings given to the self-harming behavior by the participant. From the total sample of 73 participants, we coded 18 interviews as NSSI, 29 as a suicide attempt, and 8 as a combination of NSSI and attempted suicide. Eighteen interviews were excluded from analysis because the intent of self-harm was ambiguous.

To identify and contextualize normative events, experiences, and processes among Latina teens, we included participants with no lifetime history of self-harm ($n = 28$). To select the subsample, transcripts were first randomly ordered. Then, each transcript was read and coded following the procedures outlined below. Thematic saturation occurred after analyzing 28 transcripts, at which point the selection of cases for the subsample ended.

Across each subgroup (NSSI, attempted suicide, NSSI and attempted suicide, no self-harm), the average age of the girls was 15 years. Most were born in the United States (68.7%). Participants identified with several different Hispanic subgroups, but the majority identified as Puerto Rican, Dominican, and Mexican (Table 1).

Qualitative Interview

In-depth qualitative interviews were conducted with all participants in either English ($n = 63$) or Spanish ($n = 20$), depending

upon the participant's preference. All interviewers—masters- and doctoral-level social workers and psychologists who were bilingual Latinas—were trained to encourage participants to talk freely and in-depth about topics in the interview guide to allow for as much information to emerge as possible. Prior to beginning the qualitative interview, each participant was asked standardized questions regarding self-harmful behaviors to ensure that participants who were identified as nonattempters did not have a history of self-harm at the time of the interview.

All teens participated in an interview that explored perceptions of family life and interaction; delineation of roles, responsibilities, rules, and discipline; examples and sources of conflict that occurred among family members and methods of conflict resolution; and perspectives of life outside the home, including peer relationships, dating, and school. Among girls with histories of self-harm, interviewers also elicited an account of the self-harmful behavior, including the solicitation of a detailed, retrospective account of emotional experiences and family context before, during, and after the act. All interviews were audiotaped, transcribed, and analyzed in the language of the interview by a team of bilingual and bicultural researchers. Qualitative interviews lasted between 25 and 70 min.

Data Analysis

Following Teddlie and Tashakkori (2006), we used an exploratory mixed-method analytical design, which entailed qualitative analysis of interview data followed by the quantification of qualitatively derived themes. This strategy facilitates the evaluation of patterns in the data in ways that are not always available through traditional qualitative analysis (Fakis, Hilliam, Stoneley, & Townend, 2014; Guest, MacQueen, & Namey, 2012). Although this study integrates qualitative and quantitative techniques, our approach is strongly rooted within a qualitative tradition that emphasizes the participants' perspectives and explanations of the behaviors in question (Singer, 2006). Thus, we quantify the qualitative data to make systematic comparisons across groups of

Table 1. *Characteristics of Adolescent Latinas in Subsample*

	Participants who used NSSI ($N = 18$)		Participants who attempted suicide ($N = 29$)		Participants who used NSSI and attempted suicide ($N = 8$)		Participants with no self-harm ($N = 28$)		Total participants ($N = 83$)	
	$M \pm SD$	n (%)	$M \pm SD$	n (%)	$M \pm SD$	n (%)	$M \pm SD$	n (%)	$M \pm SD$	n (%)
Age in years	15 $\pm$ 1.4		15.5 $\pm$ 2.0		15 $\pm$ 2.3		15.1 $\pm$ 2.1		15.3 $\pm$ 1.9	
11–13		2 (11.)		6 (20.7)		1 (12.5)		7 (25.0)		16 (19.3)
14–16		14 (77.8)		14 (48.3)		4 (50.0)		13 (46.4)		45 (54.2)
17–19		2 (11.1)		9 (31.0)		3 (37.5)		8 (28.6)		22 (26.5)
U.S.-born		16 (88.9)		14 (48.3)		6 (75.0)		21 (75.0)		57 (68.7)
Hispanic cultural group										
Puerto Rican		7 (38.9)		9 (31.0)		0 (0.0)		12 (42.9)		28 (33.7)
Dominican		3 (16.7)		9 (31.0)		0 (0.0)		7 (25.0)		19 (22.9)
Mexican		2 (11.1)		6 (20.7)		0 (0.0)		5 (17.9)		13 (15.7)
Colombian		1 (5.6)		1 (3.5)		2 (25.0)		3 (10.7)		7 (8.4)
Ecuadoran		0 (0.0)		3 (10.3)		0 (0.0)		0 (0.0)		3 (3.6)
Other ^a		5 (27.7)		1 (3.5)		0 (0.0)		1 (3.5)		7 (8.4)

Note. NSSI = nonsuicidal self-injury.

^a This includes participants who identified as Venezuelan, Guatemalan, Honduran, Salvadoran, and mixed.

participants (NSSI, attempted suicide, NSSI and attempted suicide, and no self-harm).

We employed a thematic framework that combined deductive and inductive coding for qualitative analysis (Arcury & Quandt, 1998). We deductively developed four broad themes to focus our attention on the primary aims of the article (Table 2). These broad codes were then systematically applied to interviews with participants who used NSSI and/or attempted suicide to identify themes that were salient to their decisions to self-harm. A second inductive coding pass was performed on coded text to identify subthemes within each broad category. For example, any event or process identified by a participant under the code "sociocultural context" constituted a subtheme. After we developed the final list of subthemes, all interviews (self-harm and no self-harm) were read and coded, with attention directed to the emergence of new themes and validation of previous themes.

Interviews were then coded and converted into numerical form (*yes* = 1, if a theme was present; *no* = 0, if a theme was not present). The first author first carried out all deductive and inductive coding using digital spreadsheet software (Meyer & Avery, 2009), after which the second author independently coded and reviewed 100% of the text, including the conversion of the qualitative data. Any discrepancies or concerns about the application of codes to sections of text were highlighted and brought to the attention of research team members, discussed, and revised according to group consensus.

Results

Analysis of the qualitative interviews revealed subtle differences in the ecodevelopmental factors surrounding Latina teens' decisions to use NSSI and/or attempt suicide. In our results, we direct attention to the ways in which adolescents explained their acts of self-harm. In doing so, we contextualize their motivations and situate their psychosocial vulnerabilities within broader familial and sociocultural contexts to understand the events, processes, and experiences that gave rise to decisions to engage in suicidal behaviors and NSSIs.

Adolescents Who Reported NSSI

Within the sample of 18 teens who reported NSSI, the majority harmed themselves through cutting ($n = 14$). Those adolescents who cut chose sharp instruments (e.g., razor blades) because of their perceived accessibility, reflecting the spur-of-the-moment decision to self-injure. As one adolescent explained, she chose to cut with a piece of broken glass because it was "the sharpest thing I could find."

In every case of cutting behavior, the decision was motivated by a need to interrupt the intensity of emotions experienced in the moment. Girls did not view their cutting as a suicidal act, but rather as a way to process thoughts, feelings, and emotions. As one 15-year-old explained,

It was in my hand [the nail file], and I was thinking, "What I'm going to do with this? I'm not going to kill myself because I do not want to die. I want to just stop feeling angry." Inside me was screaming. I was feeling really, really angry.

This sentiment—the need for emotional regulation—was echoed across participants who cut. NSSI was perceived as a way to release overwhelming emotional states, which included experiences of sadness, depression, tiredness, stress, frustration, and uselessness. Of these emotional reactions, anger figured prominently ($n = 12$). Although emotional regulation was the most frequently reported reason for cutting, three participants described an additional need to feel physical pain through cutting. One girl explained, "I just wanted to feel physical pain. I feel like part of me already felt pain, so I need the other part to feel more pain." In these cases, the desire to experience pain was a strong motivator for using NSSI.

Conversely, participants who overdosed on pills ($n = 3$) described different motivations for engaging in NSSI. In these cases, the primary aim was interpersonal: to punish or enact influence over parents. For example, one Latina described a time when her mother had broken the household rules, breaching a written contract they had that no one would enter her room without her permission: "I was like, you know what? I should drink [the pills] 'cause she broke the rules three times, not twice, but three times." In this case, the teen perceived NSSI as a way to punish her mother for breaking their written contract. Thus, NSSI could be utilized to communicate the intensity of anger toward parents with the aim of punishing them for their perceived acts of transgression.

Although the intent of NSSI differed across participants, an underlying theme in each case was control. For example, cutting provided girls with the ability to be in control of their emotions or the kind of pain inflicted. Although emotional suffering was intense, overwhelming, and chaotic, NSSI could be used directly to manage that suffering and the ways in which it was experienced. Similarly, girls who cited interpersonal motivations for NSSI expressed the salience of feeling in control. As one participant clarified, "I hate the feeling that other people can make me cry so it's a relief that they are not controlling me crying this time. I can do it myself." Thus, NSSI could be used to reframe emotional encounters wherein the adolescent was an active agent of her emotions and the emotions of others.

Table 2. *Deductive Coding Framework*

Theme	Definition
Modality	The method by which self-harm was inflicted
Intent/motivation	The participant's reason for engaging in self-harm
Emotional state	The emotions present during the moment of self-harm
Sociocultural context	An event, process, or experience the participant identified as shaping the decision to self-harm

Adolescents Who Attempted Suicide

Among the 29 girls who attempted suicide, 13 ingested pills, 8 cut, and 3 engaged in other methods of attempting suicide that included suffocation or ingesting household cleaners. The remaining five adolescents combined multiple methods, most frequently ingesting pills and cutting. In each case, the intent of self-harm was to cause death, and participants described coming to a sudden decision to end their lives.

Powerlessness was a key theme underlying the emotional states of girls who attempted suicide, and participants described the inability to identify alternative mechanisms to escape their emotional suffering. In this void, the decision to attempt suicide emerged as a possibility. As one girl explained, "I just didn't know what else to do." The primary motivation underlying attempted suicide was a desire to end overpowering feelings, and participants cited sadness and worthlessness most frequently. Unable to endure the intensity of the emotional pain, adolescents perceived suicide as the only option. As one attempter recounted, "I felt depressed. It's like a black hole that you cannot see the light. So everything is dark. I just wanted to do something about it, so I tried killing myself." She ultimately ingested more than 50 pills and lost consciousness.

Many attempters described feeling unloved and unsupported within their families, and a suicide attempt symbolized the depths of their loneliness. Yet, three girls thought their attempted suicide could improve their relationships with their parents. For example, one participant believed that her suicide attempt "would make everything better. So I figured that if they knew the way I was feeling, that I didn't want to be there, that I felt like I didn't belong, that maybe they would change." Despite the semblance of hope in this narrative, the emotional tenor of her interpersonal relationships was still predicated on the agency of others, and in this case, her parents. In the end, she still perceived herself as powerless to change the situation, echoing a theme expressed by each girl who attempted suicide.

Adolescents With NSSI and Suicide Attempts

Eight participants disclosed histories of both NSSI and attempted suicide. Five participants used multiple methods, which included cutting and ingesting pills. The three remaining participants in this subgroup caused harm to their bodies through cutting. All teens in this group distinguished acts they identified as "relieving pain" from those that were intended to cause self-inflicted death. As one participant noted, "I do not have any suicidal thoughts when I'm cutting, like, 'cause I feel I do not have control over anything, but at least, I can control that." In contrast, she attempted suicide by ingesting pills:

The reason I took the [acetaminophen] was 'cause I just couldn't take it anymore. It's like, everything got out of control. I kept thinking, "This is not my life. This is not my life. I do not want this to be my life." Then I saw the bottle of [acetaminophen] lying on my bookshelf, and I just, I just, I took out all the pills. I started counting them. I counted 14 pills. And I took the whole bunch.

Despite seemingly clear-cut differences between suicidal and NSSIs in terms of intent, several participants noted that different acts of self-harm could easily blur together. NSSI did little to alleviate patterns of interpersonal dynamics that contributed to emotional pain, and over time, the embodied relief initially

achieved through self-injury dissipated. For example, one participant turned to cutting soon after the death of her mother. Yet, one night, after a protracted argument with her father, she went to her room and saw the knife that she used to cut:

I thought about when I had cut myself. When I did it, it gave me a feeling of relief. It kind of like took my head away from all the problems and all the pain that I was feeling emotionally. But honestly, I did it [cut] again, and I still felt the same. I still felt sad and horrible, so I came to realize it was pointless . . . I just couldn't stand living anymore.

Similarly, another participant cut for several years to alleviate emotional distress, yet that same behavior soon became a way to attempt suicide when cutting no longer provided the sought-after relief. As she explained, "At first, it was like, I guess, to relieve pain. And then after, it just became a way to kill myself." Other participants, upon their realization that cutting was no longer providing relief, switched methods and ingested pills to attempt suicide.

Comparing the Sociocultural Context: Self-Harm and No Self-Harm

As noted earlier, Latina teens expressed a range of overwhelming emotions, which motivated their decisions to use NSSI and/or attempt suicide. Their narratives revealed the ways in which emotional states were ultimately rooted within broader sociocultural contexts, and participants identified several different circumstances that contributed to their decisions to engage in acts of self-harm. All participants, including those with and without histories of self-harm, reported on how they dealt with a broad range of issues, such as parental divorce, the migration of a close family member, or experiences of physical assault. Analyzing the ways in which participants reflected upon and recounted those events reveals how they differentially reacted to, interpreted, and ascribed meaning to stressors occurring in daily life. Table 3 describes the number of participants who experienced stressful life events and compares the frequency with which such circumstances were reported among those who used NSSI, attempted suicide, or had no lifetime reported history of self-harm.⁴

Fragmented family structure. Fragmented family structure emerged as the most frequent theme across all participant groups, and girls reflected on the various family losses incurred by parental divorce or separation, death, or migration. Those girls who experienced NSSI and/or attempted suicide perceived a family member's absence as salient to their decisions to engage in acts of self-harm. For example, one Latina explained,

I felt real alone, like there's no reason of me being here . . . I lost my mother. I thought at that point [of my suicide attempt] that I had lost my father because me and him were at the point where we would not

⁴Table 3 displays the most frequently cited circumstances. Participants did cite additional factors that they described as contributing to decisions to self-harm, including fights with boyfriends ($n = 4$), family reactions to participants' disclosure of sexuality as gay or bisexual ($n = 4$), having a close family member commit suicide ($n = 1$), knowing a friend who attempted suicide ($n = 1$), and depressed mental state following an abortion ($n = 1$).

Table 3. *Comparing the Sociocultural Context of Self-Harmful Behaviors*

	<i>n (%)</i>				Total participants (<i>N</i> = 83)	Example of theme in interview
	Participants who used NSSI (<i>N</i> = 18)	Participants who attempted suicide (<i>N</i> = 29)	Participants who used NSSI and attempted suicide (<i>N</i> = 8)	Participants with no history of self-harm (<i>N</i> = 28)		
Fragmented family	11 (61.1)	22 (75.9)	7 (87.5)	19 (67.9)	59 (71.1)	"When I was little, I was close to my father, like a little daddy's girl. Then when I was like 6, like around there, he had left."
Family conflict	14 (77.8)	24 (82.8)	7 (87.5)	11 (39.3)	56 (67.5)	"Sometimes I try to talk to them about, like, my day. But they get, like, you know, they'll always have something to say and we'll get into a fight."
Parental criticism	7 (38.9)	18 (62.1)	4 (50.0)	5 (17.9)	34 (41.0)	"I don't really like talking to my mom about it because she's—like she puts me down and she makes me feel worse about the problem."
Transnational stress	3 (16.7)	14 (48.3)	3 (37.5)	2 (7.1)	22 (26.5)	"I didn't want to be here, but only to go to [country of origin]. I thought, 'Better to die than be here in the U.S.'"
Bullying	7 (38.9)	2 (6.9)	3 (37.5)	10 (35.7)	22 (26.5)	"This girl at school, she decided that she doesn't like me cause she doesn't like my attitude, something like that. So she was getting this group of girls together to jump me or whatever."
Physical abuse	3 (16.7)	11 (37.9)	2 (25.0)	5 (17.9)	21 (25.3)	"Like since I was little, if I broke a page out of my notebook, or if I didn't pick up my toys after I played, he would just like come up and beat me."
Academic challenges	2 (11.1)	7 (24.1)	1 (12.5)	4 (14.3)	14 (16.9)	"There was a lot of projects due in school, all the pressure in school. And I didn't want to go to school ever. So I started thinking why should I live, live anymore?"
Sexual abuse	3 (16.7)	5 (17.2)	0 (0.0)	1 (3.6)	9 (10.8)	"There's still times that I do think about what happened, and I ask myself, like was that my fault?"
Domestic violence	0 (0.0)	5 (17.9)	2 (25.0)	3 (10.7)	10 (12.0)	"My mom and dad had a fistfight. He punched her, like eight times in a row. And I got so scared."

Note. NSSI = nonsuicidal self-injury. Participants could have expressed more than one subtheme.

even talk to each other. We would walk right by each other like if either didn't exist. So I was like, wow, my whole life came down on me. I just, I couldn't stand living anymore.

In contrast, adolescents with no history of self-harm responded to family fragmentation in more pragmatic ways by focusing on the strength of ties with others. For example, one girl explained, "I just think you have to . . . like, find people who are gonna help you. They are gonna help you get out of what you are going through, or at least help you through it." Thus, supportive interpersonal ties fostered individual resilience, which could help soothe emotional suffering that resulted from many of the challenging life circumstances described in Table 3.

Family conflict. The expression of family conflict as a theme was most frequent among girls with histories of both NSSI and an attempted suicide (87.5%), followed by girls who attempted suicide (82.8%), used NSSI (77.8%), and had no history of self-harm (39.3%). One teen explained that just prior to using NSSI, she argued with her mother about her "freedom." As she explained, "[My mom] gives me freedom, but not the freedom that I want, like, to go hang out with my friends, and like do what every other kid does as a teenager—have fun." When these arguments became particularly "intense," she would go to her room and cut her arm with a knife. This case illustrates a common pattern that was found among participants who engaged in acts of self-harm. Conflicts with parents frequently centered on different perspectives regarding autonomy, and these conflicts were interpreted by many teens as symbolizing a cultural or generational divide that could make it difficult for parents and children to connect.

Among girls with no history of self-harm, participants were either less likely to describe their relationships in terms of conflict, or they expressed an empathetic awareness of factors that contributed to less-than-optimal dynamics. As one teen noted, "I actually understand why my mother gets angry, you know, 'cause . . . if I'm not supposed to be doing something and I disobey her, she's gonna get angry." Ultimately, adolescents without self-harm were particularly cognizant of and empathetic toward social and economic stressors facing their parents.

Parental criticism. The presence of parental criticism as a theme in interviews was highest among girls who attempted suicide. As one participant who attempted suicide reflected,

It's about, like how I dress. No, not how I dress, like how I do things. I'm sloppy. Like how I do my hair. I'm not accepted. Like she doesn't accept me for who I am. And that she's very negative toward me.

Expressions of criticism ranged from negative parental judgment about appearance or behavior to verbal assaults, and participants explained that parental criticism often led to feelings of worthlessness and alienation. For example, one girl who attempted suicide noted that her father would frequently curse at her without provocation. As she recounted,

My father would say, "You are going to turn out to be a bitch just like your mother. You will not have any shame." I would be like, "How can you say these things to me if I am your daughter?"

In response to such verbal onslaughts, the teen went to the bathroom, grabbed a bottle of pills, and overdosed.

Parental criticism, although less frequent among girls with no history of self-harm, held the potential to induce emotional suffering. As one teen explained, "It's like I do not fit in. I think [my mom] doesn't really love me." Parental criticism, in all its forms, destabilized bonds of kinship and left teens feeling like outsiders in their own families.

Transnational stress. Girls who attempted suicide were more likely to report transnational stress than participants in other subgroups. Transnational stress referenced the explicit and communicated desire by participants to return to their country of origin as a result of the stress produced by their daily life in the United States. Participants described emotional trauma experienced by leaving behind those family members who were charged with raising the girls during their parents' migration. Upon family reunification with birth parents, girls felt that they were strangers in their home. As one participant noted, "I didn't know my family and they didn't know me." The perception that one was living among strangers, both in the home and community, could further exacerbate the emotional strain incurred by coming to the United States. One teen who attempted suicide noted,

When you are in your country, you feel at home. You feel good. You feel that you are independent. When you come to a country where there are different people, you feel strange. You feel like you cannot move. Because of this, I, I think it is better to stay in one place.

As this participant references, any social encounter held the potential to trigger feelings of difference, alienation, and marginalization. Girls who articulated transnational stress echoed this sentiment, and participants directly attributed transnational stress as a factor that shaped decisions to attempt suicide. As the quote in Table 3 highlights, participants perceived death to be a "better" alternative to a lonely existence in the United States.

Bullying. Approximately 25% of participants in our sample described experiences of bullying and victimization by peers, but it was least common among girls who attempted suicide. Bullying took many forms, ranging from verbal teasing to ethnic and racial discrimination or threats of violence. Girls who used NSSI reported feeling extreme and immediate anger after being teased or threatened by classmates. For example, one teen remarked,

My whole class and some seventh-graders kept making fun of me cause of my age and my weight, and I told them to stop it and they wouldn't. I got mad so I went to the bathroom, started crying, and I cut myself.

Sometimes, victimization by peers would escalate to threats or experiences of violence. As noted by one teen who cut,

The last time I cut myself was Friday, cause for no apparent reason, this girl at school, she decided that she doesn't like me cause she doesn't like my attitude, something like that. So she was getting this group of girls together to jump me or whatever.

In contrast, girls with no history of self-harm were less likely to narrate their emotional responses to bullying as immediate and overwhelming. Instead, they emphasized the advice or support they received from parents. As one participant explained,

They always make fun of me because of the sneakers I wear. They have real uptowns, I have a fake. They hate a lot on me. But every time, I tell my mom, and my mom goes up to the school.

Experiences of violence. Some adolescents reported experiences of violence in the home, including episodes of physical abuse, sexual abuse, and witnessing domestic violence. Teens who reported a suicide attempt, with or without NSSI, were most likely to recount these experiences and attribute such experiences to feelings of loneliness. The enormity of experiences of violence led the girls to conclude that they were alone for two reasons: (a) no one would be able to understand what they were undergoing, or (b) they did not want to burden someone by discussing their problems because that person was also a victim of violence. For example, one 16-year-old described the everyday terror of witnessing the domestic violence between her mother and stepfather. She dreaded coming home from school every day:

My body could be in school but my, my mind is in my house thinking, “what if one day I come from school, go to my house, and see my mother on the floor?” I cannot really tell my mother. So, for me, I just get crazy [with] all this stuff that is going on. I keep it to myself. So they build up until I cannot take anymore.

In contrast, girls who used NSSI or had no lifetime history of self-harm were more likely to turn to those family members they identified as supportive to help soothe distress brought on by experiences of violence. For example, one teen explained that although she often cut following arguments with her mother about curfew, she turned to her mother for emotional support after her father molested her sexually. As she remembers the event, “My mom was shocked at first. And she, she told me that she was glad I told her.” Her mother ultimately filed charges, and the girl explained that together, “we’ve been getting over it.”

Similarly, one participant with no history of self-harm described being raped by a stranger while she was walking home one evening. She recalled that as soon as she walked in the door after the assault, her mother knew something was wrong. Afterward, she described going through a period of aggression and engaging in physical acts against peers at school, but with the help of her mother, she was able to heal and move forward:

My mom taught me, you know, “you gotta sit down, you gotta really speak no matter how angry or how bad it is. You always come to us and tell us.” You know, your best friends in the world is your parents. ‘Cause they will never turn their back on you, never.

Academic challenges. Experiences of academic challenges, although discussed with less frequency among participants, were described as taking a significant toll on their emotional well-being. School and parental pressures to augment scholastic performance shaped intense feelings of stress. For example, one adolescent recounted, “School was getting on my nerves. I was really stressed and I decided I would do a cut every day.” As this participant’s account illustrates, decisions to use NSSI stemmed from a need to control stressed affective states produced by school difficulties.

Latinas who attempted suicide were more likely to interpret academic shortcomings as evidence of their perceived worthlessness. As one teen recounted at the time right before her attempt, “I remember that I was thinking to try to kill myself so I wouldn’t have to go to school. I wouldn’t have to explain to

people why, why my grades were bad. I wouldn’t have to be perfect.” Negative evaluations of self-worth and perceived comparison to and by others were central to this participant’s decision to attempt suicide. For this reason, young adolescents sometimes reported academic challenges as the most distressful event incurred in their daily lives.

Discussion

In this article, we used an ecodevelopmental approach to compare and situate decisions to engage or not engage in different acts of self-harm (NSSI and/or attempted suicide) within the microcontexts of everyday life, revealing how Latina teens coped with multifaceted emotions and experiences. Most teens identified specific, and often multiple, situations that induced powerful affective states and shaped decisions to inflict self-harm. In our analysis, a primary theme distinguishing NSSI and a suicide attempt was the emotional response to difficult life circumstances, and girls who used NSSI were more likely to identify anger as a predominant emotion.⁵ Adolescents who engaged in NSSI perceived their negative feelings as something that could be controlled through injurious acts upon their bodies, and they employed NSSI as a mechanism for emotional regulation. In contrast, adolescents who attempted suicide perceived isolation as a symbol of their everyday life—this loneliness could not be mitigated, only ended. However, such distinctions could easily become blurred, as evidenced in our analysis of interviews with girls who used NSSI and attempted suicide. When NSSI ceased to function as a mechanism for controlling intense emotions, girls came to sudden decisions to attempt suicide.

The American Psychiatric Association (2013) has encouraged research that examines NSSI and attempted suicide as discrete behaviors, and to some extent, our results support the extant literature that distinguishes NSSI and suicidal behavior in terms of intent. Yet, our study also points to ways in which intent occupies an uncertain position in the narratives of Latina teens who self-harm, suggesting a greater potential for ambiguity.⁶ Several participants ($n = 18$) were excluded from analysis because they were unclear about their intentions at the time the act of self-harm took place. Moreover, there was a distinct theme of chaos in the narratives of girls who self-harmed compared with their peers with no history of self-harm despite that the interview guide explored topics of conflict, stress, and trauma across all participants. Although girls who used NSSI tried to gain some semblance of control over the chaos, teens who attempted suicide felt entirely unable to enact control. Yet, the boundaries between the controllable and uncontrollable were not clear-cut, suggesting a more complicated relationship between the two behaviors. This is of particular concern given the potential for NSSI to shape decisions to attempt suicide (Klonsky, May, & Glenn, 2013).

Given the diverse, and sometimes, conflicting meanings surrounding the notion of “intent” (Chandler, 2014); broadening

⁵ Some studies have posited that girls are socialized to mute emotional expressions of anger (Chaplin, Cole, & Zahn-Waxler, 2005). Future research on the roles of gender socialization with Latino families might shed additional light on the ways NSSI is used to meet such gender expectations with Latino families.

⁶ Thanks to an anonymous reviewer for her or his suggestion regarding this point.

clinical definitions of intent to include an analysis of the communicative aspects of self-harm could be a productive arena for research and practice. Situating an adolescent within a broader context provides for an analysis of those events and experiences that preclude easy classification, and there are important sociocultural elements to consider when contextualizing Latinas' acts of self-harm—and all acts of self-harm—that go beyond a focus on intent to die or emotional regulation. For example, Latina adolescents living in the United States must continually navigate multiple, and often competing, ecodevelopmental contexts that position them between childhood and adulthood, country of origin and country of destination, family and peer, and Latino and “American.” Many Latina teens, regardless of their lifetime history of suicidal behaviors or NSSIs, discuss the salience of these multiple contexts as contributing to a sense of cultural fragmentation in their lives (Zayas, 2011).

In this article, the decision to engage (or not to engage) in self-harmful behaviors reflects the psychosocial processing of cultural fragmentation. Our analysis suggests that Latina teens with no history of self-harm are able to normalize, and thus stabilize, this fragmentation, often with the help of those in their social networks. For those girls who used NSSI, cutting provided an avenue to control the chaotic emotions produced by fragmentation. When NSSI no longer enabled control, some participants turned to suicide. Among suicide attempters with and without histories of NSSI, their perceived inability to bridge their chaotic and fragmented world led to desires for self-destruction. It might be that intent is ambiguous because adolescents feel uncertain about their place in the world because of the competing and contradictory messages they receive about who they are and who they should be. We offer this interpretation as a potential avenue for future investigation, particularly among minority populations.

In our study, there was considerable heterogeneity in the events, process, and experiences that lead to various kinds of emotional suffering described by participants. Across groups, themes related to family relational problems figured prominently, although suicide attempters with and without histories of NSSI reported a greater frequency of exposure to stressful family and life events. These findings are consistent with research on self-harmful behaviors in other racial and ethnic groups (Andover et al., 2012). For example, family relational problems have been shown to be directly related to the onset of both NSSI and attempted suicide (Adrian, Zeman, Erdley, Lisa, & Sim, 2011; Brent & Mann, 2003; Bridge, Goldstein, & Brent, 2006). Moreover, several studies have found that adolescents with a history of attempted suicide report more stressful life events than adolescents who use NSSI (Andover et al., 2012; Baetens et al., 2011; Muehlenkamp & Gutierrez, 2004; Wong et al., 2007).

However, two themes, transnational stress and bullying, emerged as particularly salient and promising for subsequent studies on self-harmful behaviors because they point to the distinct concerns and struggles faced by adolescent Latinas. Transnational stress was a prominent theme among teens who attempted suicide, but it is important to note that the frequency with which this theme surfaced in interviews reflects differences in the overall sample population. Only 48.3% of the participants who attempted suicide were U.S.-born, compared with 89% of girls who used NSSI, 75% of the girls who used NSSI and attempted suicide, and 75% of girls with no history of self-harmful behaviors.⁷ Some research has suggested that the risk for attempted suicide among immigrant

groups is because of the experience of a combination of stressors, such as dislocated systems of social support, socioeconomic strain, and discrimination (Hovey, 2000). In this sense, an attempted suicide among immigrant groups might represent an extreme form of “culture shock” (Cho & Haslam, 2010). Future research should consider the ways in which experiences of immigration produce different stressful events and give rise to different psychosocial responses that might shape decisions to attempt suicide.

Although girls who attempted suicide, both with and without histories of NSSI, reported adverse factors in their sociocultural context with greater frequency than other participants, the theme “bullying” did not follow this overall pattern. Girls who used NSSI were more likely to recount experiences of bullying than participants who attempted suicide. But unlike their peers with no history of self-harm, they rarely reported such events to their parents. To date, the extant scholarship on the relationship between peer victimization and suicidal behaviors and NSSIs reports mixed findings (Heilbron & Prinstein, 2010). Our study indicates the continued need to explore this relationship and investigate the various factors that contribute to and protect youth from engaging in NSSI following experiences of bullying, especially as related to perceived systems of social support.

Limitations

Caution should be utilized when generalizing our results for several reasons. This study was designed to be exploratory, but the use of a deductive coding framework that emphasized the sociocultural context precluded the identification of other factors that might distinguish reasons for engaging in self-harmful behaviors among Latina adolescents. Moreover, the qualitative interview was not designed to explore lifetime history of suicidal behaviors and NSSIs, even though several participants noted that they had engaged in acts of self-harm more than once. Furthermore, we did not analyze interviews with adolescents who were unsure of their intent. Continued and confirmatory research is needed to examine similarities, differences, and links between NSSI and attempted suicide, especially in ways that take into account the heterogeneity of Latina populations (e.g., place of birth; Hispanic subgroup) and the ambiguity of intent.

There is also the potential for self-selection bias because this study used a purposive sampling design. Participants were aware of the purpose of the study, and they might have been more likely to volunteer for participation because they were eager to discuss their own experiences. Despite these limitations, this exploratory study provides important insights that can be applied toward the development of strategies to improve prevention and treatment efforts.

⁷It is difficult to ascertain why a greater number of U.S.-born Latinas used NSSI compared with Latinas who were born outside of the United States. Some research points to NSSI as a cultural trend in the United States, noting that NSSI is a theme in television shows and movies and that many celebrities have talked openly about their cutting behavior (Lester, 2012). It is possible that cutting has emerged as a popular adolescent idiom by which to express distress, although confirmatory research is needed to test this hypothesis.

Implications for Assessment, Intervention, and Practice

Our study points to several implications for assessment, intervention, and practice. It is important to note that all participants in the study who engaged in self-harm were originally referred by mental health practitioners who assessed their behavior as suicidal. Considering the difficulties in assessing and differentiating NSSI and suicidal behaviors, we would like to highlight potential arenas for consideration among clinicians and researchers.

If we consider that self-harmful behaviors might reflect an adolescent's relationship to her ecological environment, assessment and intervention could begin by prioritizing the meaning of the self-harmful act from her perspective. As part of an assessment, practitioners could engage patients in a kind of miniquality interview to elicit the adolescent's own explanation and viewpoint (see Groleau, Young, & Kirmayer, 2006). For example, our study indicates that it is imperative to ask adolescents what circumstances led to the production of their intense affective states. Given that control emerged as a salient theme among girls who used NSSI, eliciting teens' perspectives on their behavior could enable a sense of empowerment in the clinical encounter. Such a discussion could indicate key domains to explore during additional intervention protocols (i.e., dealing with parental conflict and/or peer victimization). Moreover, given that some participants attempted suicide when they perceived NSSI to no longer function, enabling participants to develop awareness of their need for control might pave the way for a dialogue around sources of personal strength and resilience.

Among Latina suicide attempters, powerlessness, loneliness, and perceptions of negative self-worth played a pivotal role in decisions to attempt suicide. Attention could be directed toward helping girls shift their personal evaluations of their self-efficacy, alongside interventions that would help them to build meaningful, relational bonds with other individuals. This is especially important among girls who have recently immigrated to the United States. Acts of self-harm reveal how Latina adolescents differentially ascribe meanings to their experiences and struggles, uncovering the perceptions and beliefs that comprise their understanding of their social reality. It is here that we might find a productive starting ground for practice.

Keywords: adolescents; Latinas; nonsuicidal self-injury; qualitative research; suicidal behaviors

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Deep in the Heart of Texas: A Phenomenological Exploration of Unsheltered Homelessness

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The purpose of this qualitative study was to develop an in-depth understanding of the experience of unsheltered homelessness in Fort Worth, Texas. Eighteen individuals participated in the study; 13 were full-time residents of Fort Worth and 5 were traveling through the area via freight train. All reported long-term histories of unsheltered homelessness. Interviews were conducted in naturalistic settings; for example, on the street, under bridges, and in camps. Results indicated that the participants entered homelessness through diverse paths, but all of these paths were characterized by loss and social isolation. Many described homelessness as a threatening and dangerous experience; relying on strong street-based social networks and their own personal strengths for survival. Participants viewed shelter service providers as sources of stress and stigma to be avoided but heavily utilized street outreach services and faith-based missions. The overemphasis by providers on “fixing” people, rather than addressing immediate needs, made many participants ambivalent about traditional services. This study supports the use of nontraditional housing interventions and robust community-based approaches to care for individuals experiencing unsheltered homelessness.

Homelessness continues to represent a serious social problem in the United States with approximately 630,000 people lacking safe and stable housing each night (Department of Housing and Urban Development [HUD], 2013a). Among all people experiencing homelessness, people living unsheltered (e.g., sleeping in cars, parks, abandoned buildings, camps, and on the street) are a sizable subgroup, representing approximately 40% of all people experiencing homelessness (U.S. Interagency Council on Homelessness, 2010; HUD, 2013b).

Whereas research has focused extensively on the general problem of homelessness, only a few studies have concentrated on unsheltered homelessness (Donley & Wright, 2012). Studies that do, confirm that people experiencing unsheltered homelessness are an especially vulnerable subpopulation reporting longer histories of homelessness, and higher rates of psychiatric disorders, substance abuse, and medical problems than individuals residing in shelters. They also tend to be older, more often male, more likely to be veterans, and are more vulnerable to victimization and death (Christensen, 2009; Levitt, Culhane, DeGenova, O’Quinn, & Bainbridge, 2009; Nyamathi, Leake, & Gelberg, 2000; Lam & Rosen-

heck, 1999). Two-thirds of individuals experiencing unsheltered homelessness meet the criteria for chronic homelessness, a subclassification of people who possess a disabling condition and have experienced 1 year of continuous homelessness or four episodes of homelessness in the last 3 years (HUD, 2011, 2012).

A number of assistance services are available to people experiencing homelessness. Engaging individuals who are living unsheltered in the use of these services, however, can be challenging. If services are located in a shelter, people residing on the streets may not access them because they are unaware the services are available, are unable to enter the facility, or they may be employed and working when agencies are open (Christensen, 2009; Jost, Levitt, & Porcu, 2011; Larsen, Poortinga, & Hurdle, 2004). In addition, they may not use agency-based services because they are concerned about their physical safety or having their belongings stolen (Donley & Wright, 2012). Other programmatic barriers to service use include requirements for sobriety (Larsen et al., 2004), limits on the ability to come and go from shelter facilities (Farrell, 2010), requirements that couples sleep separately, or the lack of facilities for companion animals (Burlingham, Andrasik, Larimer, Marlatt, & Spigner, 2010; Donley & Wright, 2012). A barrier to services frequently reported by people experiencing unsheltered homelessness is negative interactions with service providers, which leave them feeling stigmatized and dehumanized (Applewhite, 1997; Christensen, 2009; Freund & Hawkins, 2004; Meschede, 2010; Ogden & Avades, 2011).

Whereas research has investigated unsheltered homelessness (population characteristics, needs, service use, etc.), many studies have relied on populations already housed or actively seeking services (Jost et al., 2011; Applewhite, 1997; Ogden & Avades, 2011; Lam & Rosenheck, 1999) or required that participants travel

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to interview locations (Donley & Wright, 2012). Only three studies in publication have collected data explicitly in naturalistic settings (e.g., on the streets, under bridges, or in camps; Levitt et al., 2009; Kryda & Compton, 2009; Larsen et al., 2004). Of these studies, however, only one (Kryda & Compton, 2009) used qualitative methods, but it exclusively explored perceptions of outreach practices and available services. The current study, therefore, recruited a community-based sample of individuals with long-term histories of unsheltered homelessness and who were outside of the service-provider network. The study then used qualitative interviews, all conducted in naturalistic settings, to explore the lived experience of unsheltered homelessness.

Context of the Present Study

Fort Worth is the fifth largest city in Texas with a population of just over 770,000 people (U.S. Census Bureau, 2014). Between 2000 and 2010, Fort Worth was the fastest growing city in the United States with a population greater than 500,000 people (City of Fort Worth, 2014). As with most large municipalities, Fort Worth grapples with the issue of homelessness. In 2013, the biennial point-in-time homeless count identified just over 1,100 individuals using emergency shelter, and 247 people who were homeless and unsheltered (Tarrant County Homeless Coalition [TCHC], 2013). Compared to the 2011 count (984 sheltered and 136 unsheltered), emergency shelter service use declined by 4% while the number of unsheltered homeless rose 106% (TCHC, 2013).

Most services available to people experiencing homelessness in Fort Worth are located in an area commonly known as East Lancaster. The area hosts two overnight emergency shelters and one day-shelter located within several hundred yards of each other. Another emergency shelter is situated approximately one third of a mile away. Additional services available in the East Lancaster area include outpatient health and mental health care, housing placement programs, inpatient substance abuse treatment, a federal Safe Haven program, and a variety of educational and training programs.

Method

Design

Quantitative methods were used to obtain demographic and personal information (age, gender, race, history of homelessness, etc.) and assess the use of locally available assistance services. Qualitative methods were used to evaluate the lived experience of unsheltered homelessness. The authors employed the qualitative methods of phenomenology proposed by Wertz (2005), whereby established theories or hypotheses were not used to frame the study. Instead, homelessness was understood to be an individually interpreted experience and survey instruments and data collection methods were designed to capture these personal perspectives. Participants received a \$20 gift card in appreciation for their involvement in the study. The study protocol was reviewed and approved by the Texas Christian University Institutional Review Board.

Recruitment

A local street outreach program assisted in identifying individuals with long histories of unsheltered homelessness who were also minimally engaged in assistance services. An additional strategy that the research team used to recruit potential participants was to visit physical locations frequented by individuals experiencing unsheltered homelessness. These locations were selected based on the research team's experience conducting research in the area and through input from other key community informants.

Data Collection

All participants participated in interviews that lasted approximately 2 hr. A structured questionnaire elicited demographic and personal information. Semistructured, open-ended questions with probes were used to explore each participant's individual path into unsheltered homelessness, their lived experience of unsheltered homelessness, and reasons they remain homeless. All interviews were audio recorded and the interviewer took detailed notes. Examples of questions asked during the interview are "what led to you living on the streets?"; "what has it been like to live on the streets?"; and "what has it been like to seek services from shelters?"

Data Analysis

Demographic and service use-related survey items were analyzed using SPSS statistics version 19 (IBM, 2010). Qualitative data analysis began after all interviews were completed and audio recordings were transcribed verbatim. Consistent with the open coding approach articulated by Glaser and Strauss (Strauss & Corbin, 1998), one member of the research team read the transcriptions, identified themes, and created a codebook. In the analytic process, the author used codes as the initial point of interpretation and employed open coding at a line-by-line level (Corbin & Strauss, 2008). The second author reviewed the transcriptions using the codebook to highlight relevant codes as they emerged from the data organically. The second author mapped the emergent codes onto axial codes and completed the open and axial coding independently. She then met with the first author to review the findings. Where the authors diverged, they returned to the data and reexamined codes and meaning making. The final themes resulted from this iterative, dynamic process of communication between the research team members.

The authors also employed several rigor criteria to minimize bias including peer debriefing, maintaining an audit trail, and deviant case analysis (Creswell, 2007; Lincoln, 1995; Lincoln & Guba, 1985). The authors met frequently to discuss the coding process and emerging themes. Chronological versions of the transcripts at different stages of coding were saved to document the dynamic analytic process. Finally, as noted in the results section, the authors sought out cases that contradicted the themes to revise and strengthen their validity for the entire sample.

Results

The strategy to use local outreach providers and other stakeholders to identify potential participants proved an effective ap-

proach. Visiting locations frequented by people who are homeless was similarly effective, but also introduced researchers to a subpopulation of individuals who were living unsheltered and traveling via freight trains. Ultimately, 18 participants were recruited to participate in the study. Thirteen (72%) were full-time residents of Fort Worth and five (28%) were individuals who were traveling via freight train but had stopped for a short period in Fort Worth.

Sample Characteristics

As shown in Table 1, participants in the total sample were predominantly male ($n = 14$, 78%) and Caucasian ($n = 12$, 67%), averaging just over 40 ($M = 41.4$, $SD = 14.1$) years old. Few ($n = 2$, 11%) reported Hispanic ethnicity, had ever been married ($n = 7$, 39%), and/or possessed some kind of health insurance ($n = 5$, 28%). One third reported serving in the United States armed forces ($n = 6$). On average, participants reported having a high school education ($M = 12.0$, $SD = 1.9$) and a majority ($n = 11$, 61%) had worked for pay in the 30 days prior to the interview. Including all sources of income, participants reported an average income of \$399 ($SD = 352.4$) dollars in the prior 30 days. Total lifetime homelessness averaged 6.2 ($SD = 4.6$) years, and current homelessness averaged 2.8 ($SD = 3.5$) years. Most ($n = 11$, 61%) participants possessed a government-issued ID, but fewer ($n = 7$, 39%) possessed the scan card required to access local services for people who are homeless (especially day and/or night shelter and meals).

Service Use

Of the 13 resident participants, only one (8%) reported using night or day shelter services at any time during the last 2 weeks. A

majority of resident participants reported using street outreach services ($n = 11$, 85%) with a similar proportion also using services at local faith-based missions ($n = 10$, 77%). Two (15%) resident participants reported they had sought care from a local emergency room, but none reported being admitted for inpatient care. No train-riding participants reported using any shelter (night and day), outreach, mission, or health care services in Fort Worth or elsewhere during the 2 weeks prior to the interview.

Experiences of Unsheltered Homelessness

Entry onto the street. Whereas participants reported entering unsheltered homelessness for a variety of reasons, the related themes of loss and social isolation were ubiquitous throughout their narratives. One woman, for example, discussed that she was physically abused by her father and abandoned on the streets:

He got drunk, he beat the heck out of me and the next morning he paid for another (hotel) room, gave me \$20 and said, "You go find your own way home." . . . Some police officers came and got me and they took me to a women's shelter . . . 13 days later I was out here on the streets.

Another participant described his parents as alcoholics unable to care for him as a child. He subsequently spent his youth moving between members of this extended family, eventually living in several state-run therapeutic residential programs. After turning 17 and being emancipated, he said "to heck with it" and began living on the streets of Fort Worth. Similarly, a female train rider stated that her family lived on an Indian reservation in Minnesota, were poor, and were ". . . all just drunks and addicts . . . not really like that much of a family I guess." With a desire to travel and few ties to her family, she began riding trains.

Table 1. Study Subgroup Demographic Characteristics

Variable ($N = 18$)	Fort Worth residents ($n = 13$) n (%)	Train riders ($n = 5$) n (%)
Gender		
Male	11 (85)	3 (60)
Female	2 (13)	2 (40)
Race		
White	9 (69)	3 (60)
Black	4 (27)	1 (20)
Native American	0	1 (20)
Hispanic	1 (8)	1 (20)
Age (M , SD)	$M = 46.5$, $SD = 10.7$	$M = 28.0$, $SD = 13.6$
Current homelessness episode in months (M , SD)	$M = 42.0$, $SD = 47.0$	$M = 29.0$, $SD = 26.3$
Total lifetime homelessness in months (M , SD)	$M = 68.3$, $SD = 48.4$	$M = 89.8$, $SD = 87.4$
Education (M , SD)	$M = 11.9$, $SD = 2.1$	$M = 12.0$, $SD = 1.2$
Ever married	6 (46)	1 (20)
Health insurance	3 (23)	2 (40)
Veteran	6 (46)	0
Critical documents		
HMIS scan card	7 (54)	0
Government ID	8 (61)	3 (60)
Work for pay	7 (54)	4 (80)
Total monthly income (dollars) (M , SD)	$M = 322.2$, $SD = 366.6$	$M = 600$, $SD = 234.5$

Note. HMIS = electronic homeless management information system.

Some participants recognized that their own use of substances contributed to their loss and social isolation, and thus, entry into the experience of unsheltered homelessness. They reported that substance abuse undermined their employment and housing, led to being arrested and incarcerated, and alienated them from family and other supports. One man, originally from Mexico and living intermittently on the streets for 8 years, explained that alcoholism made it difficult for him to keep a job and housing: "It depends, it depends. Working sometimes and don't working sometimes. Because I'm an alcoholic, I drink too much and sometimes I lost my job." Similarly, a participant who had been riding trains for just over two years ascribed his homelessness to addictions—"at least 75%, 60% of my homelessness has been, you know, it's been like an addiction thing"—but subsequently explained he had very limited family support and had been homeless since being released from prison: "Cause, like my family doesn't back me . . . just due to, you know, runnin' and runnin' amuck and this and that . . ."

Another factor, which study participants named as a reason for their homelessness was continued unemployment. One participant described being financially stable but lost his housing after he became unemployed. Another participant noted that unemployment played a role in his entering unsheltered homelessness but subsequently explained that the reason that he had lost his job was because his roommate had stolen his car and tools:

I gave him [my roommate] my car keys and he never comes back . . . all my tools in it . . . and I never saw him again . . . So I ended up sellin' everything I owned and got to stay there like a month and another 3 weeks, and finally they evicted me cause I couldn't come up with work . . .

Acknowledging that the path into unsheltered homelessness is not often the result of a single factor, this same individual explained how his job loss was even more catastrophic with no social support system to help him. Feeling alone and unsupported, he struggled to pick up the pieces: "I bet I could've found a way, you know, to get into the drive and hold my place. It's just that depression kicked in, and I ain't got no family. I didn't have anybody really to ask for help."

Several participants also attributed the challenges of transitioning from prison to their eventual homelessness. These challenges manifested differently, however, for individual participants. One man's struggle to reintegrate back into mainstream society was explicit in his narrative: "Well, I got arrested. I did 7 years in New York City Prison . . . and I had a hard time readjusting back into society." Another young man discussed that spending time in prison and having a criminal history impeded his ability to return home, ". . . I can't go home 'cause my mother says that . . . people be breakin' in them houses in her neighborhood and she fears that if I come home they would blame me." A third individual discussed that his extensive history of incarcerations undermines his ability to secure meaningful employment. With no job, he stated that housing was out of reach and he remains homeless.

Another theme echoed by many participants was that emotional challenges played a role in their entry into unsheltered homelessness. The impact of these emotional challenges, however, seems to have been magnified by the lack of a strong social support system. One man discussed that, after his wife passed away, "I, uh, hit this depression. I just hit rock bottom and I just didn't know where to go and who I should talk to." He went on to discuss that as his

depression worsened, his life deteriorated until he lost his job and was evicted from his apartment. Similarly, a man who had been living in his car for the last 5 years discussed that ongoing challenges with depression made it difficult to tolerate losing his job:

As I mentioned, I worked for American Airlines. I had been with them 17 years and I got laid off and I was devastated. I had already started going through battles of depression before this happened but I didn't realize I was going through depression at the time. And then I lost my job and it just took me all the way down.

Finally, a woman who has lived intermittently on the streets for over 10 years stated, "I just said the hell with it . . . I just wanted to be away from the stress. I'm out here 'cause I have a feelin' that my mind and my body are being destroyed."

Life on the street. Living on the streets, participants noted that it was critical to know people who could be trusted to help minimize exploitation and victimization. As one train rider stated:

We all protect each other. It's like a mutual fucking agreement, you know what I mean? When I'm around someone I care about I protect, I protect them, and they protect me when I'm vulnerable, you know what . . . Cause we're like fuckin' out there all the time.

A female participant acknowledged the importance of mutual aid and a support system when she first became homeless. With no knowledge of available resources, she struggled until she ". . . met somebody who took me under their wing, showed me about First Street Mission and Beautiful Feet Ministries and all that. And we then we set up a camp together." Ultimately, the relationship soured as her companion began abusing drugs, ". . . and in the end, all he seemed to want to do is get high on ice and beat the hell out of me . . ." Having been on the streets now for 6 years, she discussed that she had been with a new companion for several years and her living situation had improved. Asked about a typical day, she described a routine of waking up together, eating breakfast, and then parting ways as he works day-labor jobs and she panhandles. At the end of the day:

. . . I'll meet him somewhere and then we go home together. I cook dinner. We sit around and play games . . . We talk about, some of our favorite things to talk about are movies and music. And he is a musician. We talk a lot about music.

In the midst of needing safe and trustworthy companions, participants also explained that a strongly enforced social order and codes of conduct exist among the unsheltered homeless. As a man who'd been living in a camp in the woods for nearly 4 years stated:

Yeah, there are five people in my camp right now that all stay there. But I have seniority there . . . I can leave a 20 dollar bill on the ground with a rock on top of it and chances are when I come back, there will be 21 dollars there. I mean, all the people that stay with me, they're trustworthy to the bone . . . it's [a] cardinal rule: don't run, if you're a homeless person don't run up into somebody else's camp . . . Not unless you're invited.

In seeming contradiction, though, to the themes of trust, support, and order, participants also discussed negative experiences that affected their desire and ability to depend on other people experiencing homelessness. One man stated that since living on the streets he had seen ". . . a lot of crazy stuff happenin' and . . .

there's not that many decent people left in the world, you know?" Consequently, he had learned "... not [to] throw yourself out there. You don't throw yourself out in the street for somebody that you don't know because you never really know." Another participant echoed this sentiment as he discussed being physically attacked while eating at a local mission. Not understanding the motivation behind the assault, he was clearly shaken by the experience:

I had seen him before this happened, with his two children at Beautiful Feet [local mission], and he was always so tender and attentive to his kids. He'd serve 'em and set 'em up and ... and I was thinking to myself that he is really good with his kids. And then BAM! All of a sudden he attacks me and tells me he is going to kill me because he says he saw me at the bus station with my pants down. I told him it wasn't me but he didn't believe me and gave me two black eyes.

The most consistent theme among study participants was that, despite the risks of living unsheltered, they preferred this environment to sleeping in a shelter. In fact, only one participant reported sleeping in a shelter in the 2 weeks prior to participating in the study. Asked about his stay, he was clear regarding his discomfort stating, "I mean, I don't go to like eat breakfast or anything over there [the shelters]. As soon as I could, I leave there. I mean, the only time I spent over there was at night." Several other participants likened sleeping in a shelter to being in prison. One participant noted that "They lock you in and you do have to more or less fend for yourself in there. So I'd rather be out up underneath the stars, you know, lookin' up." Another man stated that "if I want to wake up at 3 o'clock in the morning and want to take a walk, I don't want nobody coming after me and telling me I can't, you know?"

Several participants were very clear that they avoid night shelters because they feel unsafe. A female train-rider described the shelter as "the wrong environment ... if you are assaulted ... it takes forever for the police to come, if you even bother to call them." One man who'd been living on the street for 7 years complained that people in shelters tend to, "... pick on the smaller people, you know ... if they see something they want, you know, they wait 'til you fall asleep or something like that and they will take it." Another man stated that he avoided shelters because residents will "... steal you blind, strip your clothes off while you are asleep. You take your shoes off and they take them. They'd whip your ass and then take whatever, you know." Confronted with these threats, one man summed up the perspective of many participants, "I'd rather stay outdoors, and that way I know I'm safe."

In addition to being unsafe, participants described shelters as unsanitary as well. A 19-year old female train rider stated that she and her partner would rather panhandle to pay for a hotel room and take a shower rather than use the shower in a shelter. Passing through El Paso, Texas, she had visited a shelter with a friend who wanted to take a shower: "It was fuckin' nasty. It was so gross. It was all moldy, nasty, rusty. Just dirt everywhere. It was disgusting." Several male participants echoed this perspective and one participant explained that he did not stay in night shelters as he did not "... wanna sleep next this guy who snores too loud or doesn't cover his mouth and he coughs on the back of my neck when I'm sleeping. The last night I slept in there a guy next to me wet his mat." Another participant stated that friends who had used shelter

services had "come out with like athlete's foot and like staph infections and like all kinds of weird stuff." Given these health risks, he stated, "... I just prefer to sleep under a bridge, you know ...?"

An additional, and related, theme to emerge from the participants' narratives of living on the street was an "othering" of themselves from people residing in emergency shelters. One man described a "dog-eat-dog" attitude among the latter and said that he avoids shelters because "they [the residents of emergency shelters] don't treat each other like human beings." Another man, living unsheltered since losing his job over 6 years ago, avoids shelters because he feels that would allow people to classify him as homeless, something he seemed determined to avoid:

If you see me walking down the street you wouldn't know I'm homeless. ... I carry myself so well that people don't know that I'm homeless, not like the people on the hill [East Lancaster] ... the only people that know I'm homeless are the people that I tell that I'm homeless.

Another process of differentiation was noted among individuals who traveled by freight trains, who distinguished themselves from the more static homeless. According to one train-riding man:

People I've met that are just homeless just don't have any motivation ... Like they're just like just sitting in a city just like rotting ... Whereas like being a traveler, like I'm actually like seeking stuff out. I'm actually like going somewhere.

Similarly, another long-term train rider said, "Yeah, people who are city hobos. People that live here 10-20 years down on the river ... they're the ones that steal from you ... We don't associate with them for a reason."

A final theme associated with living on the street was the impact of homelessness on participants' perceptions of themselves and those around them. While they uniformly avoided traditional service providers, they frequently identified their own internal resources as sources of support and survival. Some explained that they had developed a strong sense of self-reliance, pride, and independence because of living on the street. Participants even described homelessness as revelatory in regards to their character and their understanding of their own capacities and limits. As one man said, "I'm tougher than I thought was." A female train rider expressed a similar sentiment: "You know, there was a part of me that thought like maybe I would not be able to handle it. But when I started traveling I realized that I actually am tough, you know? Another individual stated, "... I think that it has strengthened me spiritually for the fact that there is not a lot that you can really put your trust in when you've got very little, you know?"

Exiting homelessness. Several key themes emerged around the issue of exiting homelessness. The first was that many participants generally perceived formal service providers and assistance services as inefficient, nonresponsive, and ineffective. For some, the homeless assistance service system itself was one of the greatest barriers they faced to exiting homelessness. For instance, one man explained he had been homeless for 7 years and had previously begun the process of enrolling in a housing program with the help of a case manager. Following up with that case manager, though, no progress had been made with his application:

I spoke to them [case manager] a while ago, you know, I said, "Hey, you remember that thing, that housing deal that you signed me up for?" They said, "Did I sign you up? I don't remember signing you up." I said, "Yeah, you went and took me right back there. You asked me a bunch of questions and stuff like that." And that was the last time I heard about it. I haven't heard nothing about it since then.

Several participants noted that services were often overly restrictive and service providers failed to match services to needs appropriately. Specifically, they complained that providers held a stereotypical view of individuals on the street expecting them all to be suffering from mental illness or substance abuse. As such, the main goal of providers seemed to be to "fix" individuals rather than to listen to each individual authentically and respond to his or her unique needs. For example, one man described a frustrating situation in which he attempted to seek help:

My experience [with a case manager] . . . was more like, "You're broken and I'm going to tell you all these different things that we can use to help fix you." I understand that there are some people that are broken, you know, and that they do need help. But it took me a long time to actually get to the resource that I felt like I needed because nobody really bothered to ask . . .

Related to the goal of "fixing" people, other participants felt that the system was nonresponsive because it possessed a limited repertoire of services, most being targeted toward people who had severe mental health or substance abuse challenges. One man, not struggling with either of these challenges stated that "the people that need the least amount of help or that have fewer obstacles to overcome . . ." are not a priority for some service providers. Another participant, acknowledging that services were often geared toward helping individuals with substance and/or mental health problems, said that he understood this focus as he had seen ". . . people walking around on Lancaster that talk to themselves and aren't in their right minds . . . and there is no way they're ever gonna be able to put it together themselves and get out of that situation." For himself, however, he wished that the services could be more broadly available and, as importantly, promoted to the people who need them:

I'm glad that there are resources when you have drawbacks, but . . . get me an education and get me some training so I can get back into work. Yeah, it took me a year or year and a half before I found out there was something like that.

Several participants explained that the disrespectful approach taken by staff at traditional programs dissuaded them from using services. One man discussed that he stopped seeking entry into a Department of Veterans Affairs case management program after being aggressively questioned about mental health and substance abuse by a case manager:

So he says, "what's wrong with you? . . . You drink? . . . You do drugs? . . . Uh, are you crazy?" I said, "I've been tryin' to convince the Department of Veterans Affairs that they've made me nuts, but they seem not to think so." He goes, "well, I tell you what, you fill out this 31-page application and we'll find out what's wrong with you." And I said, "Let me tell you the fuck what's wrong with me. I gotta go out and kill all of your country's favorite assholes and I come back to this fuckin' country and find out that there's more assholes per

capita here than anyplace in the world I've been, including you." He says, "So what do you plan on doin'?" And I said, "I'm goin' out . . . I'll find me a spot. It might be rough for the first couple of days but I'll find me a spot."

Other individuals discussed similar experiences where they felt depersonalized by staff serving large numbers of clients, concerns about their privacy, and a belief that program workers could be vindictive if they did not like their clients.

When asked about their desire to obtain housing, some resident participants expressed ambivalence. One man stated he is not driven to pursue housing as he sees other people who need it more than he does:

I've got storage. I can get my sleeping out and a tarp. Find me a place to lay down for the night, and when I get up in the morning, I fold my stuff up, take it to the storage so nobody steals it.

In the end, though, having spent 9 years living on the street, he seemed to evidence some readiness for housing as he stated ". . . [I] can't do this forever, you know." Another man also expressed an interest in housing, but previous efforts of working with case managers only led to frustration. The last time he attempted to obtain subsidized housing, he waited for 5 months only to be turned down. While he did not dismiss the idea of seeking housing again, he was not trying to obtain it currently. A third participant, who had developed a deep sense of spirituality while homeless, expressed concern that a return to housing, and in his mind materialism, might jeopardize his relationship with God:

God humbled me is basically what he did. And that is what he wants from us all. To humble ourselves before him. Now, for me, he had to do it. He had to strip me out. He had to take me down. There's a beautiful poem; it's called *Treasures*, and he talks about the hands. He says, "I can't fill you up with my treasures when you have yours in there."

Asked if he could maintain the same spiritual connection if he had housing, he stated that this relationship was ". . . his everything . . ." and, as he had not made this spiritual connection when housed previously, he was not seeking housing now. Finally, some of the participants who rode trains described their transient lifestyles as "addictive." As one veteran rider explained

Yeah, that's how it works. Like honestly once you start hopping trains and traveling, it's hard to get that outta your system. Like you can't just . . . it's really hard to just stop cause you're always gonna be . . . like lookin' at trains and bein' like . . . Oh I could get on that right now. Like, that's goin' to Jacksonville, Florida. I could totally go to Jacksonville right now. You know?

Discussion

The purpose of the current study was to explore the lived experience of individuals living unsheltered in Fort Worth, Texas, using their personal narratives to produce individually interpreted accounts of life on the street. Strengths of the study include the recruitment of a sample outside of the traditional service-provider network and the collection of data in naturalistic settings. Another strength is that the study used a phenomenological, qualitative approach to obtain rich, personal perspectives across three dimensions: entering unsheltered homelessness, living unsheltered, and

exiting unsheltered homelessness. A limitation of the study is that alternate perspectives of unsheltered homelessness may not have been documented because of the use of a small, purposefully selected sample. Another limitation of the study is that the nature of the sample precludes generalizing the findings to the larger population of people living unsheltered in Fort Worth or populations elsewhere. As noted by Padgett (2012), however, the findings of the study may be cautiously transferred to contexts with comparable populations and service settings.

The participants in this study most commonly identified loss and social isolation as the primary reasons for entering homelessness. Other factors, however, including poverty, unemployment, difficulties transitioning from prison, and substance abuse and mental health challenges, clearly played overlapping roles in their becoming homeless as well. While similar to the pathways taken by many people experiencing homelessness, sheltered or unsheltered (Morrell-Bellai, Goering, & Boydell, 2000), what seems notable is the deliberate manner in which participants in this study intentionally avoided many of the services specifically designed to help them. Instead, they relied on a street-based support system comprised of other people experiencing homelessness and outreach providers and mission programs that typically focus on meeting basic needs rather than permanent housing. This support system, however, was in direct contrast to the participants' accounts of frequent victimization encountered on the streets. Thus, the street became both a source of danger and safety.

For service providers, the connectivity that exists among individuals living on the street unsheltered is a critical consideration when conducting outreach and promoting services. If service use threatens the integrity of social support systems that are essential to survival, some people may be reluctant to seek out services or may refuse services. Alternately, because participants also reported being exploited or victimized by other people living on the street, it is critical that service providers assess the safety needs of their clients and help individuals escape dangerous circumstances whenever possible. To further complicate the situation, many participants shunned emergency shelters and considered them even more dangerous than the streets. As such, providers must be creative and resourceful as they help individuals to locate and access safe shelter.

The willingness of participants to utilize street outreach and faith-based mission services indicates they are not completely averse to seeking help from service providers. Participants described these service providers differently than traditional emergency shelter service provider, suggesting that the former are engaging with clients in a manner that is more responsive to and respectful of the needs of individuals living on the street. Many of these programs focus on meeting basic needs (hygiene products, food, clothing, transportation assistance, etc.), which individuals living on the street and unsheltered may view as their most critical necessities in the short term. This focus on basic needs, however, appears to lead to a gap in addressing housing, employment training, and employment placement.

The individuals' narratives in this study suggest several opportunities to improve the manner in which service providers engage with and assist people who are homeless and living unsheltered. First, providers need to ensure that services are provided in a manner that supports the dignity of clients. An initial step in this process would be for providers to assess the relationship between

client and worker as these relationships may be a source of power inequities that leave clients feeling objectified (Hoffman & Coffey, 2008). Another step in supporting client dignity is for providers to ensure that service provision decisions are made collaboratively. Many participants in this study reported that providers only seemed interested in providing services they had assumed that the clients needed, especially mental health and substance abuse treatment. To increase client engagement in services, it is critical that providers shed preconceived notions regarding client service needs and support client self-determination through collaborative assessment, problem identification, and service provision (Acosta & Toro, 2000).

The second opportunity to improve how service providers assist people who are homeless and living unsheltered is through direct linkages to housing. In this study, only one individual explicitly stated he was not interested in housing. Some participants expressed ambivalence, but most clearly stated they were open to leaving the streets. Given the negative perceptions held by participants toward emergency shelters and their extensive periods of homelessness, a housing intervention applicable to this population is Housing First (Tsemberis, Gulcur, & Nakae, 2004). Originally developed for individuals experiencing homelessness who were also diagnosed with a severe mental illness, this evidence-based approach (U.S. Interagency Council on Homelessness, 2010a; Pearson, Montgomery, & Locke, 2009) places individuals directly into housing, bypassing the intermediate steps used in older approaches. Once in housing, clients are offered supportive services that emphasize individual choice and self determination (Kertesz, Crouch, Milby, Cusimano, & Schumacher, 2009; Pearson et al., 2009; Tsemberis et al., 2004). Considering that most participants sought services from outreach providers and faith-based missions, these programs seem to offer excellent opportunities for the application of Housing First.

Conclusion

In the current study, individuals experiencing unsheltered homelessness discussed their paths into homelessness, experiences while homeless, and feelings about exiting homelessness while participating in qualitative interviews. Findings suggest that these individuals eschew traditional services because of perceived threats in these environments and a dehumanizing approach among service providers. In fact, a key finding of this study is that unsheltered homelessness itself appears to be partially a response to an oppressive service network; the decision to live on the street rather than in a shelter represents an effort to retain a sense of personal dignity and self-determination. To engage and serve people who are homeless and unsheltered more effectively, it is, therefore, essential that service providers create and improve upon the built environment of shelters so that they are spaces of physical and psychological safety rather than victimization and trauma. It is also critical that providers develop collaborative and respectful relationships with people who are experiencing unsheltered homelessness. Another opportunity to assist this population appears to be in the form of Housing First. To implement this approach with this population successfully, however, requires providers initiate the service where these individuals are—on the streets. This means integrating permanent housing services into street outreach and mission programs, while also being attentive to how established social support systems among people who are homeless and unsheltered may promote or inhibit the effectiveness of this ap-

proach. In addition, future research can aid in these efforts by continuing to explore the direct experiences of individuals living on the street, and thus, helping to dismantle stereotypes and promote the dignity and humanity of this population.

Keywords: homelessness; unsheltered; qualitative; phenomenological; naturalistic

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Happiness on the Street: Overall Happiness Among Homeless People in Madrid (Spain)

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This article tests a hypothesized model of overall happiness among homeless people in Spain. The research was conducted based on a representative sample of homeless people in Madrid ($n = 235$), all adults, who had spent the night before the interview in a shelter for homeless people, on the street or in other places not initially designed for sleeping, or who were in supervised accommodation for homeless people at the time of the interview. Information was gathered using a structured interview. The results obtained show that around half of the homeless people in Madrid said that they were happy. A positive meta-stereotype and a better perceived general health were associated with a higher overall happiness, while feelings of loneliness were associated with a lower overall happiness. Happiness also showed a significant effect on future expectations. Disabilities and handicaps had a significant effect on perceived general health, which was in turn associated with overall happiness among homeless people.

In Spain, a fifth of the population (21.8%) live below the poverty level (Eurostat, 2012), and among those suffering from the highest degree of social exclusion and the most difficult life situations are the homeless. Homeless people not only live in a situation of extreme poverty, but also suffer from a high degree of family and social disengagement, and have great difficulties in achieving social and employment reintegration and suffer from significant health problems (Muñoz, Vázquez, & Vázquez, 2003; Vázquez, Panadero, Martín, & Diaz-Pescador, 2015). The Spanish National Institute of Statistics (2012) estimates that the homeless population in Spain cared for in accommodation and food distribution centers amounts to 22,938 people, and various nongovernmental organizations estimate that there are more than 30,000 homeless people (Plujá i Calderon, 2011).

A great deal of research has been conducted on the most negative aspects experienced by homeless people, including stressful life events (Muñoz, Panadero, Santos, & Quiroga, 2005; Padgett, Smith, Henwood & Tiderington, 2012), physical and mental health problems (Hodgson, Shelton, Van den Bree, & Los, 2013), and mortality (Arnautovska, Sveticic, & De Leo, 2014; Hwang, Wilkins, Tjepkema, O'Campo, & Dunn, 2009; Morrison,

2009). However, few studies have focused on the positive aspects experienced by homeless people, such as their overall happiness or their well-being (Panadero, Vázquez, Guillén, Martín, & Cabrera, 2013).

Research on homelessness appears to converge on the conclusion that material deprivation generally takes a heavy psychological toll on people (Biswas-Diener, 2008), and homelessness is associated with relatively low levels of subjective well-being and negative satisfaction with life (Biswas-Diener & Diener, 2006). Factors such as a poor diet, income insecurity, and poor quality housing adversely affect subjective well-being (Biswas-Diener, 2008).

Rojas (2006) notes that poverty has often been considered a situation in which the level of well-being is very low, and Graham (2005) notes that extreme poverty is assumed to have a highly negative effect on happiness. Various authors have stressed the relationship between income and happiness (Diener, Sandvik, Seidlitz, & Diener, 1993; Argyle, 1999). A common perception among authors is that it is difficult for a very poor person to be happy and in cases where this occurs, their happiness is attributed to the very low level of their future expectations, or their ability to adapt to their apparently unfortunate situation (Rojas, 2011).

Meanwhile, Biswas-Diener (2008) notes that the relationship between income and happiness is low compared to other factors contributing to subjective well-being, although material well-being is particularly important for the subjective well-being of those living in impoverished conditions. This correlation is curvilinear, so that money appears to be more closely correlated with subjective well-being at lower economic levels (Biswas-Diener, 2008). Rojas (2011) points out that the relationship between income and satisfaction in areas of life other than the financial sphere is negligible, meaning that income levels alone predict virtually nothing about satisfaction in other areas that are relevant for the individual. It is therefore common to find happy people with very

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low incomes, which could explain why these individuals obtain a great deal of satisfaction in other areas of their lives (Panadero et al., 2013; Rojas, 2008; Vázquez, 2013).

The scientific literature indicates that social relationships and stable links with friends and community to a large extent predict subjective well-being and general happiness (Argyle, 1999; Diener & Seligman, 2002; Gallagher & Vella-Brodrick, 2008), while the lack of social relationships, or social relationships of poor quality, have a significant negative impact on happiness (Campbell, 1981; Dolan, Peasgood, & White, 2008).

Likewise, research shows a positive relationship between health and happiness (Schimmel, 2009; Dolan et al., 2008)—an aspect that is also observed among homeless people (Panadero et al., 2013; Rew, 2002; Runquist & Reed, 2007). In this regard, the health-related variable that is most closely correlated with overall happiness is the subjective perception of health (Diener, Suh, Lucas, & Smith, 1999).

Similarly, Panadero et al. (2013) found that the combination of six independent variables (“Feelings of loneliness and abandonment,” “Suffering from a disability,” “Suffering from a serious or chronic illness,” “Perception of health,” “Future expectations,” and “Religiosity”) provided the best possible discrimination between homeless people in Madrid who were happy and those who were unhappy.

Moreover, Zúñiga, Vázquez, and Panadero (2012) noted that the overall happiness reported by homeless people in Madrid was positively correlated with the use of a positive meta-stereotype. Vorauer, Main, and O’Connell (1998) use the term *meta-stereotype* to refer to the beliefs that the members of an ingroup have concerning the stereotypes assigned to them by an outgroup. Whether as a result of direct or vicarious exposure to prejudiced behavior, socialization within the group and/or another social learning mechanism, the members of a stereotyped group may notice and become aware of other groups’ cognitive representations of them (Saiz, Merino, & Quilaqueo, 2009). Meta-stereotypes therefore provide information about the differences between the two groups as perceived by the outgroup, and are a source of comparison for the ingroup members. A negative meta-stereotype could therefore contribute negatively to the group members’ social identity, and may be particularly dangerous if it leads people to believe that this negative description is accurate as regards their own group, and therefore themselves (Klein & Azzi, 2001).

Shelton and Richeson (2005) have highlighted the tendency for individuals to avoid contact with members of other groups when they believe that these groups do not wish to come into contact with them. Fear and anxiety about how they expect to be treated make people avoid contact. In the case of the homeless, the stereotypes about this group have very negative characteristics, which lead to negative attitudes toward this group that may seriously hinder processes of integration (Hocking & Lawrence, 2000).

An in-depth study of the overall level of happiness of people in a situation of social exclusion and the factors with the greatest influence on this may provide very important information for initiatives to improve their quality of life (Vázquez, 2013; Vázquez, Panadero, & Rivas, 2015). This article could be a contribution in this direction, through the presentation of an explanatory model for the overall happiness expressed by the homeless people. This work was derived from the hypothesis that regardless

of their financial situation, homeless people in Madrid can achieve overall levels of happiness. This overall happiness is related to specific variables such health, religious belief, or social support, and includes subjective perceptions about various items (e.g., future expectations, meta-stereotypes) mostly related to their situation of homelessness.

Method

Sample

The research was conducted based on a representative sample of homeless people in Madrid, consisting of 235 adults who had spent the night before the interview in a shelter for homeless people, on the street or in other places not initially designed for sleeping (e.g., ATMs, cars, abandoned buildings, tunnels, tube stations; Toro, 1998), or who were in supervised accommodation for homeless people (apartments and guest houses) at the time of the interview.

The sample size was determined beforehand, based on the available data for the total number of homeless people in the city of Madrid. A strategy was implemented involving random sampling of participants for all housing resources available to the homeless in Madrid (14 shelters and 8 other supervised accommodations). The process involved proportionately and randomly selecting a given number of participants for the interviews based upon each resource’s capacity. The sample selection in the street was also carried out randomly and proportionally, based on the number of homeless people sleeping in the streets of Madrid according to the figures obtained from the most recent count carried out in the city (Cabrera, Muñoz, & Sánchez, 2008).

The characteristics of the sample are shown in Table 1.

As can be seen in Table 1, most participants were male, of Spanish origin, with a secondary or higher level of education. For the most part, these characteristics parallel the study’s findings, demonstrating, through relevant research, the plight of the homeless in Madrid (Panadero & Vázquez, 2012).

After explaining the aims of the investigation and the treatment that would be given to the data obtained, the informed consent of the participants was requested, and those that took part were

Table 1. *Characteristics of Homeless People in Madrid (Spain)*

Characteristics	<i>n</i>	%
Sex		
Male	195	83.0%
Female	40	17.0%
Age [Mean (<i>SD</i>)]		47.64 (11.94)
Nationality		
Spanish	170	72.6%
Foreign	61	26.0%
Both	2	0.9%
Education		
None (illiterate)	5	2.1%
None (literate)	7	3.0%
Special education	1	0.4%
Primary education	68	28.9%
Secondary education	121	51.5%
University education	31	13.2%

assured that their complete anonymity would be respected at all times.

Instruments

Following previous studies (Muñoz, Vázquez, & Cruzado, 1995; Muñoz, Vázquez, Bermejo & Vázquez, 1999; Muñoz et al., 2003, 2005), the information was therefore gathered using a structured interview, which enabled the problems associated with homeless peoples' difficulties with reading and understanding to be circumvented. The interviews were conducted as privately as possible (in an office, room, etc.). Field "street" interviews were carried out at sites chosen by the participant (in a cafeteria, on a bench, etc.), without other people nearby. They gathered information on various aspects related to homeless people in Madrid, and included several questions regarding overall happiness, future expectations, meta-stereotypes, disabilities or handicaps, perceived general health, religious beliefs, and loneliness.

Overall happiness. This information was collected using the Faces Scale (see Figure 1; Andrews & Withey, 1976). The Faces Scale is a single-item measuring instrument, comprised of seven faces, each representing a scale from maximum to minimum of perceived happiness. This scale is particularly effective for children, and has provided accurate results for groups with comprehension difficulties and/or low academic levels (Vazquez, 2013; Vazquez, Panadero & Rivas, 2015). For this reason, it was considered appropriate to use the Faces Scale with homeless people in Madrid, where people exhibiting these characteristics were found.

Meta-stereotypes. This information was collected using the Homeless Meta-Stereotypes Questionnaire (HMSQ; Zúñiga et al., 2012). This instrument is designed to measure the meta-stereotypes used by homeless people, and consists of 32 items grouped on three scales: the Positive Meta-Stereotype (reflecting a positive image), the Negative Meta-Stereotype (reflecting a negative image), and the Indulgent Meta-Stereotype (reflecting an ambivalent image; i.e., despite presenting negative characteristics they have a condescending and tolerant perspective, which to some extent considers homeless people as victims of circumstance, affected by the situation in which they find themselves). For the Negative Meta-Stereotype Scale (13 items) the Cronbach's Alpha was .86 and the biserial correlations ranged from .536 to .768. For the Indulgent Meta-Stereotype Scale (9 items) the Cronbach's Alpha was .70 and the item-test correlations ranged from .477 to .627. For the Positive Meta-Stereotype Scale (10 items) Alpha was .82 and the biserial correlations ranged from .520 to .719.

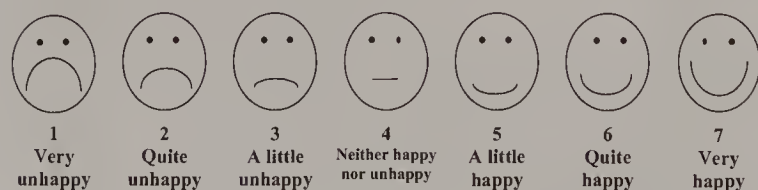


Figure 1. Faces Scale. Which of the following faces best represents your overall level of happiness?

The information regarding the various issues addressed was collected using the following questions, whose results have been published previously (Panadero et al., 2013):

- Disability or handicap: "Do you suffer from any disability or handicap (physical, sensory, mental . . .)?" with the response options *Yes* and *No*.
- Perceived general health: "What is your general state of health?" with the response options *Very good*, *Good*, *Neither good nor poor*, *Poor*, and *Very poor*.
- Religious beliefs: "What are your religious beliefs?" with the response options *Catholic*, *Evangelical*, *Muslim*, *Other religion*, *Agnostic*, *Atheist*, *Indifferent*, *Others*. This variable was recoded for the data analysis, with a distinction made between *Does not identify with any religion* (agnostic, atheist, indifferent), and *Identifies with a religion*.
- Loneliness: "To what extent do you feel lonely?" with the response options *Not at all*, *Not much*, *Quite a lot*, *A lot*.
- Future expectations: "Do you believe that your outlook for the future is . . .?" with the response options *Better than the present*, *Roughly the same as the present*, *Worse than the present*, and, *Hopeless*.

Data Analysis

The database was developed and processed using the SPSS statistical analysis and data management system (version 19.0 for Windows). The data obtained was used to undertake descriptive analyses that included information on specific characteristics of homeless people in Madrid.

When making comparisons between the groups, the χ^2 "Chi square" statistic was used for nominal variables, and the Student-*t* test for independent samples for continuous variables. To facilitate comparisons for nominal variables between interviewees according to their happiness, the overall happiness variable was dichotomized to distinguish between individuals who said they were unhappy (very unhappy, quite unhappy, and a little unhappy) and those who said they were happy (very happy, quite happy, and a little happy). The 67 interviewees who said they were "neither happy nor unhappy" and the eight interviewees who provided no data in that respect were not included in the sample.

Amos version 20.0 was used to perform path analysis to test our happiness model. Path analysis is an extension of multiple regression, and provides a more effective and direct way of modeling complex relationships between variables (Lei & Wu, 2007). Statistical analysis of the differences between individuals who were happy and those that were unhappy guided the selection of independent variables. As a consequence, in the model we included those variables in which both groups differed in a statistically significant way: disability or handicap, perceived general health, religious beliefs, loneliness, and indulgent meta-stereotype. We also decided to include positive meta-stereotypes because of their theoretical interest (Klein & Azzi, 2001; Panadero et al., 2013). In accordance with usual criteria (Byrne, 2001), we used several goodness-of-fit indicators to assess the estimated model: chi square, relative chi square (χ^2/DF), root mean square error of approximation (RMSEA), and comparative fit index (CFI). For the chi-square, a nonsignificant chi-square indicates that the model fit the data well, and χ^2/DF ratio ≤ 2 or 3 are adequate (Schreiber,

Nora, Stage, Barlow, & King, 2006). For the RMSEA index, values between 0 and .05 indicate a very good fit, and values between .06 and .08 indicate a reasonable fit (Schreiber et al., 2006). For the CFI, values $>.95$ (Hooper, Coughlan, & Mullen, 2008) or $>.96$ (Hu & Bentler, 1999) are generally recommended.

Results

Table 2 contains information on the level of overall happiness reported by homeless people in Madrid using the instrument shown in Figure 1.

As can be seen in Table 2, fewer than half the homeless people in Madrid (46.7%) said they were generally happy, while one in five (21.2%) described themselves as unhappy; 28.5% said they were “neither happy nor unhappy.”

Analysis of various sociodemographic characteristics of homeless people in Madrid showed no statistically significant differences between those who reported being happy and those who said they were unhappy, based on variables such as age, $t(158) = -0.637$; $p = .525$, sex, $\chi^2(1) = 2.795$; $p = .095$, nationality, $\chi^2(2) = 1.000$; $p = .606$, and level of education, $\chi^2(9) = 7.153$; $p < .621$. Furthermore, no statistically significant differences were observed between happy and unhappy homeless people in Madrid for variables such as their housing situation in the month prior to the interview—having slept in the street, $\chi^2(1) = 0.306$; $p = .580$ or in a shelter, $\chi^2(1) = 0.264$; $p = .607$.

Table 3 shows the differences in the average scores between happy and unhappy homeless people in Madrid in the various scales of the HMSQ.

As can be seen in Table 3, no statistically significant differences were observed between happy and unhappy homeless people for the Negative Meta-Stereotype and Positive Meta-Stereotype Scales. However, unhappy homeless people showed higher scores than happy homeless people in the Indulgent Meta-Stereotype Scale, thus reflecting an ambivalent image.

The hypothesized model of overall happiness among homeless people is presented in Figure 2. As previously mentioned, the empirical results of univariate analysis and the theoretical interest guided the selection of independent variables for the model. As a result, indulgent and positive meta-stereotypes were incorporated into the model, as well as the variables that had previously been found to have differences depending on the level of perceived happiness (Panadero et al., 2013): disability or handicap, perceived general health, religious beliefs, and loneliness. Negative meta-stereotypes were excluded from the model, as they would not contribute significant relevant information.

Table 2. Overall Happiness Among Homeless People in Madrid

Level of overall happiness	<i>n</i>	%
Very unhappy	17	7.2%
Quite unhappy	9	3.8%
A little unhappy	24	10.2%
Neither happy nor unhappy	67	28.5%
A little happy	56	23.8%
Quite happy	29	12.3%
Very happy	25	10.6%
DK/NA	8	3.4%

The standardized coefficients are presented on each arrow and the statistical significance for these coefficients is represented with asterisks. Goodness-of-fit indicators supported the proposed model. The chi-square was not significant, $\chi^2(18) = 20.342$; $p = .314$, and the relative chi-square was adequate ($\chi^2/DF = 1.130$). The CFI = .975 was good, as was the obtained RMSEA = .024. This model explained 21% of the variance in happiness.

In this model, a positive meta-stereotype and a better perceived general health were associated with a higher level of overall happiness, while feelings of loneliness were associated with a lower overall happiness. Overall happiness was also significantly related to future expectations.

An indulgent meta-stereotype, disability or handicap, and religious beliefs were not significantly associated with overall happiness. However, a disability or handicap had a significant impact on perceived general health, which was in turn related to overall happiness.

Discussion

Around half the homeless people of Madrid said they were happy despite the extreme poverty in which they live, although extreme poverty has been considered as being very negative for happiness (Graham, 2005). According to the results reported by Rojas (2011), homeless people in Madrid are more than just consumers, and there are things in their lives other than money. As a result, although their incomes are very low, they obtain satisfaction in other areas of their lives (Panadero et al., 2013), which could affect the substantial percentage of interviewees who reported being happy. Rojas (2011) notes that the level of income in itself predicts virtually nothing about satisfaction in other areas that are relevant for the individual, and life satisfaction is an overall synthesis of individuals' satisfaction with various areas of their lives.

Among homeless people in Madrid, no differences in overall happiness reported were observed based on the characteristics and circumstances mentioned in the scientific literature as predictors for happiness, with the exception of aspects related to loneliness and health (Panadero et al., 2013). No differences according to gender were observed in the percentage of homeless people who reported being happy, despite the fact that, as pointed out by Stevenson and Wolfers (2009), women generally tend to have lower levels of subjective well-being than men. The housing situation of homeless people also seems to have no impact on reported happiness among those interviewed, with similar percentages of happy interviewees observed among those who slept on the street and among those who used shelters or other accommodation.

The hypothesized model of overall happiness among homeless people studied in this article indicates that the variables with the greatest effect on the overall happiness of homeless people in Madrid are the use of a positive meta-stereotype, having a positive perception of their health (which is directly linked to not suffering from a disability or handicap), and not feeling lonely. The model also indicates that overall happiness has a strong impact on homeless people's expectations for the future.

The use of a positive meta-stereotype, which reflects a positive image of homeless people, appears to influence the overall happiness of those who use it. In line with the results reported by Klein and Azzi (2001), a positive meta-stereotype can positively con-

Table 3. Differences in the Average Scores Between Happy and Unhappy Homeless People in the Various Scales of the Homeless Meta-Stereotypes Questionnaire

	Happy (<i>n</i> = 110)	Unhappy (<i>n</i> = 50)	<i>t</i>
Positive Meta-Stereotype–Mean (<i>SD</i>)	3.98 (3.165)	3.31 (2.593)	–1.008
Negative Meta-Stereotype–Mean (<i>SD</i>)	9.23 (3.957)	9.79 (3.427)	0.755
Indulgent Meta-Stereotype–Mean (<i>SD</i>)	7.01 (2.196)	7.94 (1.136)	2.985**

** $p \leq .01$.

tribute to the group members' social identity, and have a positive impact on their overall happiness.

Health is considered a relevant factor in helping to predict overall happiness (Diener & Seligman, 2004; Lyubomirsky, Tkach, & DiMatteo, 2006; Okun & George, 1984; Verbrugge, Reoma, & Gruber-Baldini, 1994). A positive perception of health had a significant positive effect on the overall happiness of homeless people in Madrid, which was consistent with the results reported by Diener et al. (1999) on the relationship between overall happiness and subjective perception of health. According to the model of happiness studied, although suffering from a disability or handicap does not seem to have a direct impact on overall happiness, it does have a strong influence on the subjective perception of health.

Various authors emphasize that social relationships are necessary for happiness (Diener & Oishi, 2005; Diener & Seligman, 2002), and that people are happy when they are close to other people (Pavot, Diener, & Fujita, 1990). However, a lack of social relations, or poor quality social relations, has a significant negative impact on happiness (Campbell, 1981; Dolan et al., 2008). These issues could explain the importance of feelings of loneliness within the general happiness identified by the proposed model of overall happiness.

Not feeling lonely and a perceived good level of health are the two factors that appear to have the greatest impact on the general happiness of homeless people in Madrid, as citizens experiencing social exclusion in a developed country. These factors are to some

extent the same as those reported for a group at risk of social exclusion living in a less developed country (Vázquez, 2013), which highlighted the subjective perception of health and social relations as the main sources of overall happiness.

Religiosity does not appear to be directly related to overall happiness in the model studied, although several studies have highlighted the existence of a direct relationship between religiosity and general happiness (Lazar & Bjorck, 2008; Myers, 2000), despite a larger percentage of the homeless people in Madrid who identified themselves as belonging to a religion saying that they were happy.

Easterlin (2001) notes that people tend to think that they were worse off in the past and that they will be much better off in the future, even when their perception of happiness experienced remains constant. In this respect, the proposed model highlights a strong direct relationship between general happiness and future expectations. The overall feeling of happiness seems to induce optimistic cognitions, leading to better expectations for the future (Panadero et al., 2013).

The research uses a representative sample of the homeless population in Madrid, which means that it is impossible to apply these findings to other contexts. Because the study is cross-sectional, it is difficult to establish causal relationships across the different variables of overall happiness. Regardless of the limitations of this work mentioned above, it may be inferred that overall happiness is related to a person's expectations of the future. Regardless of their income and their housing situation, homeless

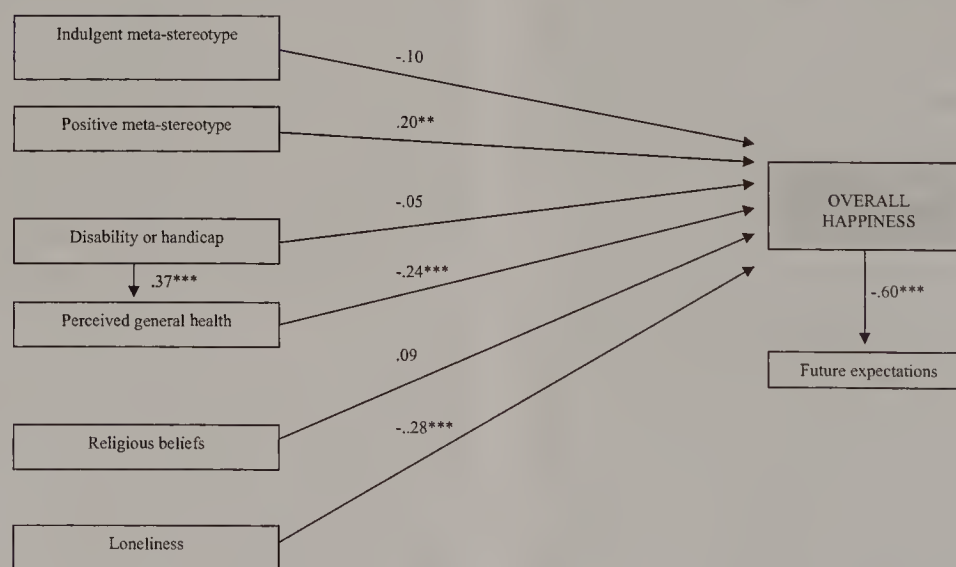


Figure 2. Hypothesized model of overall happiness among homeless people. The number next to each connector is the value of the standardized regression weight. ** $p \leq .01$. *** $p \leq .001$.

people may achieve adequate levels of overall happiness, in which specific cognitive variables seem to play a relevant role, including perception of health, feelings of loneliness, meta-stereotypes, and so forth. The study's findings may therefore be useful when designing programs and intervention strategies geared to increasing overall happiness. With positive results, the quality of life improves and the normalization process progresses.

Keywords: homeless people; poverty; overall happiness; Spain

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Positive Aspects of Being a Heterosexual Ally to Lesbian, Gay, Bisexual and Transgender (LGBT) People

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Research on heterosexual allies has focused on heterosexual identity development models and pathways to ally activism. The positive aspects or positive experiences of identifying as an ally to lesbian, gay, bisexual, and transgender (LGBT) identified individuals and communities have received little attention. Using an online survey of participants recruited from LGBT ally related social media, we collected open-ended responses to a question about the positive aspects of self-identifying as a heterosexual ally. A final analytic sample of 292 self-identified male and female heterosexual adults (age 18–71, $M = 33.47$, $SD = 13.32$) provided responses that generated 8 themes. Positive aspects of being a heterosexual ally were: (a) increased knowledge and awareness, (b) upholding values of justice, (c) beneficial individual relationships, (d) community belonging, (e) educating others, (f) being a role model, (g) using social privilege, and (h) speaking out and taking a stand. The findings suggest that being a heterosexual ally is rewarding and may enhance individual well-being. These findings provide information that may contribute to effective ally development efforts.

Allies are individuals who are members of a privileged social group who support and advocate for members of an oppressed group (Washington & Evans, 1991). Heterosexual allies may serve as advocates for lesbian, gay, bisexual, and transgender (LGBT) communities at multiple levels, from one-on-one interactions to high-profile social activism. Heterosexual allies are important to ending stigma and achieving equal rights for LGBT individuals.

The pervasive social stigma against LGBT identities has prompted research focusing on the (negative) attitudes of heterosexuals and the correlates of these (negative) attitudes (Herek, 2002, Herek, 2009; Norton & Herek, 2013). In turn, intervention studies have primarily focused on reducing these negative attitudes, most often through education and/or interpersonal contact with lesbian and gay people (see Bartos, Berger, & Hegarty, 2014 for a review). Recent findings, however, suggest that positive attitudes, or allophilia, for LGBT people explain unique variance in ally related behaviors such as attending LGBT-related events

and participating in discussions about LGBT rights (Fingerhut, 2011). Thus, in addition to reducing prejudice, it is important to also focus on understanding and facilitating the positive attitudes, experiences, and outcomes of heterosexual allies.

Knowledge about people who self-identify as heterosexual allies is limited to a handful of studies (reviewed below). While this literature explores the process of ally development and the challenges of identifying as a heterosexual ally, it does not explicitly inquire about the positive experiences, feelings, and rewards that individuals associate with identifying as a heterosexual ally. In the current study, we specifically explored the perceptions of positive experiences and rewards that accompany identifying as a heterosexual ally.

The positive experiences of heterosexual allies may be conceptually linked to sources of well-being such as meaning, purpose, and social connection (Ryan, Huta, & Deci, 2008; Ryff & Singer, 2008). Understanding the contributions of heterosexual allies' positive experiences to their well-being also may contribute to more effective ally development training and ultimately may contribute to the larger goal of transforming social stigma and prejudice. Therefore, to begin to understand the possible role of the positive aspects and rewards of identifying as a heterosexual ally, we first sought to explicate these experiences.

Literature Review

Several qualitative studies have inquired about the motives of heterosexual allies. Most notably, Russell (2011) interviewed 127 active heterosexual allies over a period of 17 years about their

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motives for engaging in LGBT activism. Their often complex motivations for public activism on behalf of LGBT rights fell into two overarching categories: (a) the desire to act in alignment with their deeply held principles and values such as justice, civil rights, and religious/moral beliefs, and (b) their professional and personal experiences in their families, relationships, and communities.

The importance of acting in congruence with one's values was also highlighted in findings from an interview study of 12 heterosexual allies who were nominated by local LGBT community members (Duhigg, Rostosky, Gray, & Wimsatt, 2010). These allies were asked about past experiences and values that motivated their ally activism. These experiences included a meaningful friendship with an LGBT person and the recognition of privilege and oppression that was contradictory to their deeply held humanitarian values. These allies also reported that their activism led to new insights, self-awareness, and knowledge about their own sexual identity and the diversity of sexuality that exists within the LGBT community. In addition to some fears of rejection, guilt, and other negative emotions, half of these heterosexual allies reported that being an ally brought specific rewards including friendship and connections with others, a sense of belonging, positive feelings about themselves, and personal and professional recognition.

Several additional qualitative studies of heterosexual allies have focused on specific professional roles and contexts. For instance, Ryan, Broad, Walsh, and Nutter (2013) interviewed university staff and faculty members of an LGBTQ allies' organization. The 13 heterosexual-identified participants ascribed their motivation for participating in the group to their professional roles and responsibilities to support LGBTQ students. The authors noted that these narratives focused on identifying as a professional ally within an educational context, and not on the highly personal work of heterosexual identity development, its challenges, and its outcomes.

In two qualitative studies of psychologists (Asta & Vacha-Haase, 2013; Borgman, 2009), participants revealed that they were influenced to be allies as a result of their personal relationships with LGBT people. They were motivated to continue their ally development by mentors and role models who encouraged and reinforced their growth and development. In both of these studies, participants shared the challenges of resolving internal conflicts and negative emotions such as guilt.

Each of these studies also offered hints at positive aspects of being a "professional ally." In Asta and Vacha-Haase's (2013) telephone interviews with 14 counseling psychologists' in university counseling centers, participants noted that their experiences as allies increased their confidence as they advocated for LGBT people in the context of their work. In Borgman's (2009) interviews with 11 psychologists who identified as both Christians and heterosexual allies, participants revealed that resolving conflicts and successfully integrating these identities was accompanied by a sense of increased empathy and greater therapeutic effectiveness.

Other studies of heterosexual allies have sampled university students. For instance, DiStefano, Croteau, Anderson, Kampa-Kokesch, and Bullard (2000) analyzed the open-ended responses of 87 undergraduate, heterosexual student members of an LGBT network within a national student affairs professional organization. In addition to some difficult emotions, internal conflicts, and negative reactions from others in response to their ally related efforts, these students also described positive emotions including a

sense of pride. The authors conclude, among other things, that being an ally is, overall, a positive experience that is worthy of deeper understanding.

Two qualitative studies have analyzed students' written reflections about their involvement in LGBT ally training. In one study, 11 undergraduate honors students expressed their fears of "coming out" as allies, their desire for role models, and their lack of knowledge and skills. By the end of the course they felt empowered as allies with new knowledge and skills and a sense of connection. One student wrote, "Being an ally has affected my life for the better" (Ji, Du Bois, & Finnessy, 2009, p. 420). These students also noted the importance of receiving positive reinforcement for their learning and their efforts.

Likewise, in an analysis of written reflection papers at the end of a year-long course for 10 counseling graduate student research team members (Dillon et al., 2004), and in a survey of 46 heterosexual members of a gay-straight alliance (Goldstein & Davis, 2010), researchers found that students struggled with their fears of rejection from others who might assume they were gay or lesbian. Yet they valued the positive support they found within the group as they developed their ally identities.

Other qualitative studies of university students have similarly noted initial fears of rejection for identifying as a heterosexual ally and then growing confidence and feelings of connection. Specifically, Getz and Kirkley (2003, 2006) interviewed 20 participants who were trained to be ally educators in a Roman Catholic university setting. Fourteen of these participants were heterosexual and described their initial fears that others would assume they were gay or lesbian. Over the course of the training and involvement in educating others, they experienced positive feelings of growing confidence, connection, and engagement as self-identified allies.

In sum, the majority of studies of heterosexual allies have focused on motivations and challenges that accompany identifying as a heterosexual ally. However, the larger literature on the role of positive experiences and feelings suggests that articulating and understanding the positive aspects of identifying as a heterosexual ally may be important to a more complete understanding of developing and training allies and ending stigma and prejudice against LGBT people (see Gonzalez, Riggle, & Rostosky, 2014). The previous work reviewed above suggests that positive emotions, experiences, and rewards may be present in meaningful ways in the experiences of being a heterosexual ally. The purpose of this study was to build on this previous work by directly and specifically asking a nationally recruited sample of self-identified male or female heterosexual allies about their perceptions of the positive aspects of being an ally to LGBT individuals.

Method

Participant Recruitment and Sample Description

Announcements about the study were emailed and posted on online message boards of several national and regional LGBT and straight ally organizations. Individuals who were at least 18 years of age and who self-identified as a straight/heterosexual ally to LGBT individuals were invited to complete an online survey. The informed consent page stated that the purpose of the study was "to document the positives and strengths that individuals perceive they

have experienced as allies” and to better understand “the rewards of being a straight ally.” Recipients were also encouraged to forward the announcement about the study to other individuals who met the criteria and who might be interested in participating. All study procedures and materials were approved by the university institutional review board.

Survey data were submitted by 369 participants. We dropped from the final analytic sample 69 individuals who reported their sexual identity as other than “heterosexual/straight” and seven participants who did not provide a response to the open-ended question that could be coded. The final sample consisted of 292 self-identified heterosexual/straight participants.

Participants in the sample resided in 31 different U.S. states (two participants did not report their state of residence). Participants ranged in age from 18 to 71 ($M = 33.47$ years; $SD = 13.32$). Of the sample, 75% identified as female and 25% identified as male. The participants self-identified as European American/White (85%), Biracial/Multiracial (6%), African American/Black (3%), Hispanic/Latino/a/South American (2%), Asian American/Pacific American (2%), and Other (2%). The educational background of the sample was: high school diploma (1%); some college or technical school (22%); bachelor’s degree (19%); some post-baccalaureate or graduate work (20%); and advanced graduate degree (38%). The current relationship status of the sample was: married (38%), single (23%), in a committed relationship (20%), dating (7%), in a domestic partnership/cohabiting (7%), divorced/separated (3%), and other (2%). Participants self-reported their religious and/or spiritual beliefs as none (37%), other (22%), Protestant (18%), Catholic (14%), Jewish (8%), and Buddhist (1%).

Data Collection Instrument and Procedures

The online study began with an informed consent page that detailed the purpose of the study. Participants selected an acknowledgment button that indicated they were at least 18 years of age and had read and fully understood the informed consent form. In addition to the demographic information, participants were asked to respond to the following open-ended question in a text box:

Please tell us below what you think the positive things are about being an ALLY for lesbian, gay, bisexual, and transgender individuals. Please describe as many positive aspects as you think are important and in as much detail and with examples if you wish. We appreciate hearing your personal stories.

Data Analysis

The length of responses submitted by the participants varied from a single phrase or sentence to multiple paragraphs. These responses were systematically coded using thematic analysis (Braun & Clarke, 2006). To ensure the validity of our identified themes, we used a consensus-building process with three primary coders and an external auditor to finalize the thematic structure of the data. The primary coders consisted of one faculty member experienced in qualitative methods and two graduate students who received training in the methodology prior to beginning the coding process. The external auditor was an experienced qualitative researcher and faculty member. All coders had previous experience in research on LGBT and straight ally health and well-being.

Following Braun and Clarke’s (2006) steps for conducting thematic analysis, the two primary coders began by individually reviewing a subset of the first 88 participant responses and developing a list of possible codes. The coders met and discussed their impressions and agreed on an initial set of codes. The coders then coded the first subset through careful reading of the participants’ responses. After this subset of data was coded separately, the two coders met to compare their findings. Discrepancies in codes were sent to the faculty coder for resolution. This coder reviewed all codes and gave feedback on the thematic structure, which resulted in a working set of codes. Eight themes were collaboratively determined to capture all of the codes. The two primary coders separately coded the remaining subset of data and recoded the first subset into the identified themes. After meeting to compare findings, discrepancies were sent to the faculty coder for review and resolution.

The external auditor then read the coded data and provided feedback and suggestions for revisions. Data coded into each theme were reviewed and discussed. Minor revisions were made in the coding of several responses. Data in each theme were read and evaluated by the external auditor and discrepancies in coding were discussed and reconciled until all four members of the research team reached consensus on the findings.

Results

The majority of participants ($N = 283$) identified at least one positive aspect of being an ally to LGBT individuals and a majority identified more than one. A total of 579 meaning units (Giorgi, 1985) from this dataset of participant responses were coded. Eight themes emerged from the data that represent the positive aspects of identifying as an ally: (a) increased knowledge and awareness, (b) upholding values of justice, (c) beneficial individual relationships, (d) community belonging, (e) educating others, (f) being a role model, (g) using social privilege, and, (h) speaking out and taking a stand.

The identified themes are interrelated. For instance, in many participants’ experience, individual relationships also provided a sense of belonging to the larger community, or participating in social activism accompanied a feeling of community belonging. Thus, many participants provided responses that included more than one theme. The percentage of participants who discussed each theme is listed in Table 1. The presentation of the eight themes is ordered to be consistent with the post hoc analysis of their alignment with the levels of the socioecological system (e.g., Bronfenbrenner, 1994). Broadly considered, these themes can be grouped into three distinct, yet interrelated levels: (a) intrapersonal growth (increased knowledge and awareness and living according to one’s values); (b) interpersonal connection (beneficial interpersonal relationships and community belonging); and (c) community/societal contributions (educate others, be a role model, use one’s privilege, and speak out and take a stand). Each theme is illustrated below with direct quotes from participant survey responses.

Increased Knowledge and Awareness

Participants gained increased knowledge, experiences, and awareness from being a straight ally to LGBT individuals. A

Table 1. *Positive Aspects of Being a Heterosexual Ally to LGBT Individuals (N = 292)*

Themes	Characteristics	% Participants
Intrapersonal growth		
Increased knowledge and awareness	Learning new things about the self, others, culture, society, privilege, etc.	30
Upholding values	Pride and satisfaction in living by one's deeply held values of justice, morality, and equality	50
Interpersonal connection		
Beneficial relationships	Feeling connected; providing and receiving support from others.	54
Community belonging	Feeling a valued part of the LGBT community.	8
Community/societal contributions		
Educating others	Educating others about LGBT and minority issues	12
Being a role model	Serving as a role model for children as well as for other straight adults	6
Using social privilege	Actively using heterosexual privilege (and other privileged statuses) on behalf of LGBT equality	10
Speaking out and taking a stand	Acting publicly to advance social justice	27

Note. LGBT = lesbian, gay, bisexual, and transgender. 579 total meaning units were coded into themes. (Participants' responses may have included more than one theme).

28-year-old female from Florida summarized her experience as an ally:

I think that being an ally helps with perspective taking and empathy. I have always felt that I supported individuals to be confident in their sexuality, regardless of orientation, and I have always advocated for equal rights. But having friends who identify as LGBT has raised my awareness of some of the challenges they encounter, and thus has made me think more critically about politics and culture.

Some participants discussed more generally the benefit of increasing awareness of other cultures, identities, gender, and sexual fluidity. A 27-year-old male from Ohio stated, "Being an ally allows me to develop a relationship with people from all walks of life. This, in turn, makes [me] more aware of my own identity. Being an ally allows for a greater understanding [of] people different than myself."

Other participants made distinctions between gaining sexual or gender identity specific knowledge and more general knowledge about privilege, oppression, and minority rights. A 20-year-old male from Virginia commented:

I like being an ally because I am able to get different perspectives on the world. Being in the sociologically dominant groups (white, hetero male), I, and others, sometimes do not see hidden injustices or trends. Having someone you know who is directly affected by these things can open your eyes to what society is really like.

Similarly, other participants stated that being an ally gave them important knowledge and skills and the confidence to use them. For instance, a 44-year-old male from Connecticut wrote:

Being an ally for the LGBT community is the BEST training for dealing with, and existing in a functional pluralistic society. In short, it makes you a better citizen, prepares you for the challenges of ignorance (both your own and that found in others), and equips you with the ability to recognize prejudice wherever it may rear its ugly head.

Heterosexual ally participants valued the knowledge and awareness they gained. They specifically noted gains in knowledge about their own sexual identity development and greater awareness

of privilege and oppression, both in relation to the LGBT community and more broadly. These participants appreciated having a deeper understanding of their own privileged social identities in relation to members of oppressed groups.

Upholding Values of Justice

Participants expressed that being a heterosexual ally to LGBT individuals allows them to live in accordance with intrinsic values of justice, morality, and equality. A 30-year-old female noted:

This is such a strange question. The advantage of being an ally to LGBT people is that you can live your life normally without suffering from the cognitive dissonance associated with many negative viewpoints. Taking a positive view of everyone allows you to flourish and grow, and fosters spiritual and personal development in the community. What other option is there but to be an LGBT ally?

Other participants made similar statements that acting as an ally allows them to live according to their values. A 21-year-old female from Ohio wrote:

The positive thing about being an Ally is that you know you are doing the right thing. You know you are being accepting to all people and leaving behind discrimination and hate. It's about being a good person. The benefits are that you are doing a service to society by breaking free of the stigma associated with LGBT people and saying that you are NOT ok with discrimination.

Participants perceived that being an ally led to personal growth because they gained knowledge and self-awareness that allowed them to explore their values. For many allies, this process of learning and development seem to be a direct result of contact with LGBT individuals. Living in alignment with their deeply held values was a positive aspect of their identities as heterosexual allies.

Beneficial Individual Relationships

Participants benefited from supporting others and/or receiving support from others as a result of being a heterosexual ally. For

example, a 22-year-old female from Kentucky provided support to a friend during his coming-out process:

I feel that being an ALLY for the LGBT community is something that is important in opening me to other people's lifestyles and ideas about life and what we do in our community both in our town and across the nation. I come from a small town that is very religious and conservative, especially when it comes to the LGBT community. I only had one friend growing up who identified as such, and it was something he kept well under wraps in order to avoid familial consequences and trouble in school. I supported him when he did finally come out to his family, and while I could understand their hurt, I was more proud to be a part of helping my friend realize himself and start living as he felt most comfortable.

Heterosexual allies also received support in relationships with LGBT individuals. One participant, a 63-year-old female from Maryland reported,

As an ally, I open my life to experience new friendships, new ideas, diverse outlooks and opinions. I have an opportunity to meet many wonderful people that have touched my life. Each individual has unique gifts and talents that contribute to the quality of [my] life.

Thus, participants reported that, as allies, their lives were enriched by the relationships that they formed. They derived satisfaction from providing support to LGBT people. They also appreciated the support that they, in turn, received.

Community Belonging

Participants reported that being an ally helped them gain access to a new community. For example, a 20-year-old female from Illinois commented that as an ally, she is a member of the LGBT community. She noted that being a member of the LGBT community provided "a sense of collectiveness between everyone involved . . . a sanctuary for individuals of all sorts." A 33-year-old female from New York expressed difficulty with identifying as an ally because of her strong sense of belonging within the LGBT community:

Maybe I'm naive but I don't even really consider myself an ally, just a not-insane person. My husband and I are kind of like queer straight people—have been dubbed such by our many gay friends. So it doesn't feel like this other community that I'm allied with, it feels like a community that I'm part of.

For these participants, identifying as a heterosexual ally expanded their social connections and strengthened their interpersonal relationships, often giving them access to a diverse community to which they now belong. According to these allies, access to the LGBT community provided them with a sense of connection and belonging to a group of like-minded political and social activists.

Educating Others

Participants indicated that educating others about LGBT and minority issues is a positive aspect of being a heterosexual ally. A 26-year-old female from New York stated:

One of the positive things about being an ally is that I have the opportunity to serve as an advocate to other higher education profes-

sionals about the needs and ways to support the LGBTIAP population. Through being an ally I have been able to serve as a voice of reason when speaking to other administrators about how to support LGBT individuals and [by] helping to consult on how to build a more inclusive community.

Allies enjoyed being leaders and advocates on behalf of LGBT people. They discussed the rewards they experienced from serving as a resource to other heterosexual people who may be less advanced in their knowledge and awareness of LGBT issues. Through educating others, participants found satisfaction in impacting societal change one person at a time.

Being a Role Model

Participants commented that being a positive role model for children was a positive aspect of being a heterosexual ally. For example, a 21-year-old female from Texas responded,

I believe the positive thing about being an ally is . . . it teaches our children that people are people and you treat them how you would like to be treated, no matter who they are, what they look like.

Other participants noted that they were role models to other adults. A 43-year-old male from Ohio commented, "As a white, hetero male, who is very visible as an ally, I can serve as a role model for other hetero males." Participants found their own particular social identities gave them a specific role in influencing others to become allies. As role models for others, allies found satisfaction in using their voices and perspectives in ways that affirmed LGBT lives and supported the larger goal of equality for everyone.

Using Social Privilege

Participants commented on the rewards of using their heterosexual privilege in a positive way that fulfilled their responsibility as a member of a privileged group. A 27-year-old female from Connecticut said, "Being an ally is extremely important to me. I feel that it is my obligation (as a person in the majority) to stand up for those that are not being treated equally." The 43-year-old ally from Ohio, above, wrote that in addition to being a role model, "I can also challenge homophobia in ways that are more difficult for folks who identify as LGBTIQ." Similarly a 36-year-old female from Kentucky reported, "As an ally, I can use my voice, my power and my heterosexual privilege to speak out against injustice."

Participants noted that their heterosexual privilege gave them a sense of responsibility for their actions toward LGBT people and in relation to other heterosexual-identified people. They had a sense of awareness of the importance of using their heterosexual privilege to make LGBT people's lives better. Their unique role in working toward LGBT equality was a positive aspect of being a heterosexual ally.

Speaking Out and Taking a Stand

Participants stated that they benefited from engaging in ally activism by speaking out and taking a stand. These actions en-

hanced their sense of empowerment and efficacy. The 36-year old Kentucky ally above also wrote,

For many years I was supportive of gay rights but never spoke up because I didn't really feel like I had much to say as a heterosexual. But now, I really see it as a basic issue for human rights.

Similarly, a 32-year old male from Ohio shared:

When a college student, particularly a White male like myself, sees me stand up and question his language or actions, then the message is sent very clearly that that is not to be tolerated. Hopefully if my actions as an ally change the actions of those who are not supportive of the lifestyle, even one person, then I will have made the world a better place for my GLBT brothers and sisters. They should be afforded the same privileges that I have.

These participants used their heterosexual identities and privilege to publicly take a stand on behalf of LGBT equality and social justice. These opportunities to speak out and take a public stand were rewarding and satisfying. Participants communicated a sense of pride in asserting their solidarity with LGBT rights.

Other Responses

Finally, we note that 10 respondents provided responses that answered the open-ended question more globally or philosophically rather than specifically. Six of these participants made statements about people being "all the same." For example, a 66-year-old female from Kentucky wrote,

I believe LGBT people are the same as any others and I see no difference in the kind of attitudes I have about them as about anyone else. Some are wonderful; some are less wonderful. Therefore I believe what is important is to be loving to all people.

Similarly, an additional four participants stated that they do not focus on being an ally to LGBT individuals. For example, a 26-year-old male from Kentucky stated, "I don't go out of my way to ally myself with people simply because of their sexual preferences. I value all my friends and family for who they are, not by sexuality." These participants' responses were placed in an "other" category because the responses did not directly address the research question of interest and reflected more global values and experiences.

Discussion

The participants in this study perceived that their ally identity provided them with knowledge and awareness, satisfying interpersonal relationships and community belonging, and a sense of meaning and purpose as they actively contributed to social change. These positive themes are consistent with factors that have been found to be important to psychological well-being (e.g., Ryff & Singer, 2008). For example, personal growth is a component of psychological well-being. The participants in this study perceived that being a heterosexual ally fostered their personal growth in knowledge, awareness, and skills. Thus, participants perceived that being a heterosexual ally gave them opportunities to "be a better person" and to live according to their highest values. These experiences are consistent with models of eudaimonia, which focus on the content and process of a life well-lived (see Ryan et al., 2008).

Positive relations with others is another central factor in psychological well-being. The heterosexual allies in the current study noted that satisfying relationships with others and connection to the LGBT community were positive aspects of their ally identity and behavior. This finding is consistent with theoretical assumptions that relatedness is a basic human need (along with autonomy and competence) and that the satisfaction of these basic needs is prerequisite to personal growth and well-being (e.g., Deci & Ryan, 2000).

The heterosexual allies in this study were also engaged in intentional efforts to change society in positive ways and found these efforts to be positive and fulfilling parts of their lives. These findings are consistent with cultivating psychological well-being through finding purpose in life, particularly in finding meaning by contributing to the greater good. This finding is consistent with conceptualizations of the links between eudaimonia and prosocial behavior (see Ryan et al., 2008).

Together these findings suggest that being a heterosexual ally to the LGBT community is accompanied by positive experiences that are consistent with the attainment of psychological well-being. Future research might build on the current study to test hypotheses about the relationship between being a heterosexual ally, eudaimonia, and well-being. Considering our findings in relation to models of eudaimonia suggests that being an ally may be one "way of living focused on what is intrinsically worthwhile to human beings" (Ryan et al., 2008, p. 147), which manifests in personal growth, deep relationships, and positive contributions to society.

Understanding the positive aspects of being a heterosexual ally may also be important to designing effective ally training programs. Previous research has reported that allies are motivated to be allies because of previous personal relationships with LGBT people and by their deeply held values regarding social justice and equality (Duhigg et al., 2010; Russell, 2011). The findings from the current study suggest that these factors also provide important intrinsic rewards that facilitate continued commitment to being allies. Ally training programs can build recognition of these intrinsic rewards into the training and thereby potentially increase effectiveness.

Our findings suggest that allies find it rewarding to be included in the LGBT community. Past research on ally experience has found that allies sometimes perceive that their efforts and involvement are not always welcome by members of the LGBT community. For example, Duhigg and colleagues (2010) found that allies were as likely to perceive negative reactions as well as positive reactions from the local LGBT community. In another study, 14 predoctoral psychology interns and psychologists perceived mixed messages about their ally work from the LGBT community (Asta & Vacha-Haase, 2013). Professionals who perceived positive messages from members of the LGBT community reported that encouragement and appreciation from LGBT individuals contributed to their continued ally work. However, other participants shared stories about negative reactions from LGBT individuals that caused them to question their ally identity and cease ally work (Asta & Vacha-Haase, 2013). These findings, together with our finding that community belonging is a positive aspect of being a heterosexual ally, suggest that heterosexual allies might benefit from training in the recognition of minority stress and how anticipated rejection from heterosexual-identified people might impact

LGBT community members' interactions with them. Practice in communicating effectively with LGBT community members might increase the positive and rewarding aspects of heterosexual allies' contributions.

Ally training programs might benefit from more focused ally-to-ally mentoring and role modeling. Previous qualitative studies have suggested that heterosexual individuals become allies when they interact with a role model or guide who teaches them the knowledge, skills, and attitudes they need and when they receive positive feedback to increase their confidence about their ally work (Broido, 2000; DiStefano et al., 2000; Getz & Kirkley, 2006; Ji et al., 2009; Washington & Evans, 1991). Our findings suggest that it is rewarding for heterosexual-identified allies to serve as role models for other heterosexual-identified people. Thus, heterosexual allies may be effective trainers of other heterosexual allies, teaching the skills and knowledge and providing the role modeling, encouragement, and reinforcement that potential allies need (Asta & Vacha-Haase, 2013). This type of mentoring may be intrinsically rewarding and may increase the likelihood of success in creating new allies. Using their own testimonials about the positive aspects of being a heterosexual ally may also be a very important part of the effective training that heterosexual allies can provide.

These suggestions depart significantly from the traditional focus on changing negative attitudes using prejudice-reduction interventions, such as panels of LGBT identified individuals, readings, or in-group/out-group exercises. Focusing on positive aspects of ally identity and behavior may supplement and enhance approaches to ally training that focus on increasing participants' understanding of privilege and oppression.

Most of the previous studies have used small samples of university students or staff (e.g., Asta & Vacha-Haase, 2013; Getz & Kirkley, 2003, 2006; Goldstein & Davis, 2010; Ji et al., 2009; Ryan et al., 2013; Stotzer, 2009) or members of one local community (Duhigg et al., 2010). By using a brief online survey to collect open-ended responses, we were able to extend previous research by recruiting one of the largest samples to date of self-identified heterosexual allies from national organizations. Still, the participants in this sample were self-selected, limited to those with access to the Internet, and connected to organizations or other persons that received the announcement about the study. Given that the resulting sample is predominately female, Caucasian, and college educated, generalizing these results to other demographic groups should be done with caution. A more diverse sample of heterosexual allies may reveal additional positive aspects.

Other qualitative studies have noted that people who have oppressed identities are often motivated to work on behalf of equality for other oppressed groups whose identities they do not share (DiStefano et al., 2000). Future research should attempt to understand the experiences of allies of color, those with less education or economic resources, and allies from specific religious groups. Glenda Russell (personal communication, 2009) has noted that it is important for LGB-identified people to attend to their own ally development and to use whatever social privilege they hold to advocate for other communities that suffer stigma and discrimination. Future research studies on LGB allies and heterosexual allies to trans-identified communities and communities of color are needed.

Whereas it is important to continue to understand the challenges that allies experience and how they overcome those challenges, the findings from this study suggest that heterosexual allies to the LGBT community have positive experiences and perceive rewards that may enhance their well-being. Therefore, we suggest that future research efforts test the utility of incorporating the positive aspects of being a heterosexual ally into interventions with potential allies in educational settings, the workplace, and the community. Ally training may be enhanced by capitalizing on the positive aspects of being an ally, including increased knowledge and awareness, alignment with deeply held values about social justice and equality, and the intrinsic psychosocial rewards of satisfying relationships and community belonging. Providing allies with opportunities to educate others, be role models, use their privilege, and otherwise contribute are important to sustaining ally motivation and commitment to social change. These behaviors are also intrinsically rewarding and may contribute to individual well-being as well as social change.

Keywords: heterosexual allies; qualitative; lesbian; gay; bisexual; transgender

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Building Resilience: A Qualitative Study of Spanish Women Who Have Suffered Intimate Partner Violence

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The scientific literature reveals the importance of the resilience process in females who have experienced intimate partner violence (IPV). However, despite the importance of the cultural context in the process of resilience, there are no investigations exploring this phenomenon in Spain. This study used grounded theory to explore the factors that contribute to building resilience in Spanish women who have undergone IPV. A sample of 22 women who had experienced IPV participated in the study (mean age = 46.45 years, $SD = 10.49$). Findings revealed that these women were capable of using various factors, both individual and external, that promoted resilience. The women employed the following individual factors: physical activity, rediscovering oneself, altruism, control over one's life, creativity, spirituality, focus on the present, sense of humor, introspection, optimism, and projects and goals. The external resilience factors were housing, informal social support, and formal social support. Findings indicate that these factors can vary from one woman to the next and that some of these factors promoted the use of other factors in the development of resilience. The implications for clinical interventions with survivors are discussed.

As a consequence of intimate partner violence (IPV), women can develop several psychological problems, including posttraumatic stress disorder (PTSD), depression, substance abuse, and suicide or suicidal ideation (Calvete, Estévez, & Corral, 2007; Graham-Bermann, Sularz, & Howell, 2011; Macy, Renz, & Pelino, 2013). Nevertheless, not all survivors suffer such adverse consequences; in fact, many of them are resilient in the face of abuse (Perez, Johnson, & Wright, 2012). Unfortunately, research has tended to ignore the study of the factors that help survivors to build resilience (Anderson, Renner, & Danis, 2012). Despite the fact that the concept of resilience is complex, most authors agree that it is a dynamic process encompassing positive adaptation within a context of significant adversity (Luthar, Cicchetti, & Becker, 2000). Furthermore, resilience is associated with several other concepts, which, although they overlap, constitute different concepts: recovery, posttraumatic growth, adaptive coping, and empowerment.

Clinical recovery is understood as the complete or partial remission of physical or psychological symptoms and a return to

premorbid levels of functioning (Bellack, 2006; Lieberman et al., 2008). Whereas the level of performance must be global in several domains (such as personal, work, and physical) to be considered as clinical recovery, resilience does not involve an overall positive adaptation (Rutter, 2013; Windle, 2011). Therefore, a person can be resilient and not be recovered. Vogel-Scibilia et al. (2009) define resilience as the ability to overcome symptoms or setbacks through recovery, that is, it can be a good pathway toward recovery, but it does not ensure its achievement. Similarly, several authors (Robertson & Cooper, 2013; Youssef & Luthans, 2007) consider resilience as part of the recovery process, but with an individual and differentiated entity.

On the other hand, the concept of posttraumatic growth is closely related to resilience and recovery. Although posttraumatic growth can emerge as a consequence of a resilient overcoming of the adversity, it represents a different concept. Rutter (2013) proposed that resilience is not the achievement of a superior level of adaptation, but rather, it involves continuing a normal life course despite adversity. The current study focused on the process of resilience in women who have survived IPV.

Regarding coping strategies, a person with successful coping skills may be resilient. However, not all resilient persons necessarily use successful coping strategies, as they may live in a protective environment that compensates for their lack of effective coping strategies (Mandleco & Peery, 2000). Finally, resilience and empowerment have been used interchangeably in the scientific literature (Cattaneo & Chapman, 2010), causing considerable confusion. However, some authors (e.g., Brodsky & Cattaneo, 2013) suggest that both concepts are differentiated by internally (resilience) versus externally (empowerment) focused change goals. On

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the other hand, for some authors, empowerment refers to a process that facilitates women's access to the skills and resources required to effectively cope with traumas (Johnson, Worell, & Chandler, 2005).

Previous studies have revealed that women who have experienced IPV draw on different protective resources to develop resilience (Gillum, Sullivan, & Bybee, 2006; Perez et al., 2012; Roditti, Schultz, Gillette, & de la Rosa, 2010). Among the individual factors, spirituality has been identified as an important protective factor for women who have experienced abuse (Anderson et al., 2012; Farley, 2007; Watlington & Murphy, 2006). For example, Gillum et al. (2006) found that 97% of the participants of their sample had identified spirituality as a source of strength. Adaptive coping also contributes to the reduction of the adverse consequences of maltreatment (Rodriguez, 2011). However, the results concerning the type of coping strategies used by women and the consequences of such strategies on their mental health are inconsistent (Flicker, Cerulli, Swogger, & Talbot, 2012). For example, there is some consistency in reports finding that avoidance strategies predict worse results, whereas the results concerning approach strategies, such as problem solving, are more inconsistent (Calvete, Corral, & Estévez, 2008; Taft, Resick, Panuzio, Vogt, & Mechanic, 2007). Empowerment is another protective factor that attenuates the sequelae of trauma (Song & Shih, 2010; Wright, Perez, & Johnson, 2010). Other less studied individual factors that intervene in the resilience process of women who have experienced IPV are creativity (Smith, 2003; Taylor, 2004), setting goals and objectives (Song & Shih, 2010; Taylor, 2004), optimism (Anderson et al., 2012; Taylor, 2004), introspection (Senter & Caldwell, 2002), sense of humor (Davis, 2002), altruism (Giles & Curren, 2007; Oke, 2008), and rediscovering oneself (Oke, 2008; Song & Shih, 2010; Yick, 2008).

Regarding external factors, prior research has shown that social support, both formal and informal, helps women to be resilient (Buesa & Calvete, 2013; Farley, 2007; Watlington & Murphy, 2006). Moreover, as many women lose resources such as housing and economic security (Roberts & Burman, 2007; Sullivan & Gillum, 2001), providing these resources can be important for the resilience process (Carlson, McNutt, Choi, & Rose, 2002; Rodriguez, 2011; Senter & Caldwell, 2002; Werner-Wilson, Zimmerman, & Whalen, 2000). For instance, Carlson et al. (2002) found that employment acted as a protective factor against the development of depressive and anxiety symptoms in women. Additional external resources include absence of economic hardship (Carlson et al., 2002; Williams & Mickelson, 2004), support for childcare (Morrison, Page, Sehl, & Smith, 1986; Wettersten et al., 2004), community services (Hayati, Eriksson, Hakimi, Högberg, & Emmelin, 2013; Wettersten et al., 2004), and social justice (Garcia & McManimon, 2011; Werner-Wilson et al., 2000).

Although the above studies contribute to identifying resilience factors in survivors of IPV, one of the limitations is that most studies have considered only one or a few protective factors simultaneously, and an assessment of multiple factors in an integrative schema is required to better understand the interplay between factors. For example, a few studies have found some relationships among protective factors in the process of resilience, such as, for example, using therapy to increase introspective ability and/or to extend the social support network (Senter & Caldwell, 2002; Smith, 2003).

In addition, previous studies conducted with IPV survivors have shown that women who scored highest in resilience have fewer symptoms associated with abuse (Humphreys, 2003; Jaramillo-Vélez, Ospina-Muñoz, Cabarcas-Iglesias, & Humphreys, 2005; Roditti et al., 2010). This could suggest that levels of resiliency are higher in recovered women than in unrecovered women. To date, there are no studies comparing differences in the levels of resilience in women who have recovered from the aftermath of abuse and those who have not recovered from these sequelae. However, this association has been found in other types of adversity such as depression (Dowrick, Kokanovic, Hegarty, Griffiths, & Gunn, 2008), eating disorders (Las Hayas et al., 2014), and schizophrenia (Torgalsbøen, 2012). With this in mind, this study compared women who had recovered and women who had not recovered from abuse.

Furthermore, the resilience process differs across cultures (Cyrulnik, 2002; Ungar, 2011). It is therefore necessary to understand the resilience process of survivors within a specific cultural and social context (Oke, 2008; Roditti et al., 2010). Regarding the role of culture, researchers have focused on providing information on the risk factors associated with the culture (e.g., Colombini, Mayhew, Ali, Shuib, & Watts, 2013; Roditti et al., 2010; Tang, Wong, & Cheung, 2002; Xu et al., 2005). However, some studies have found that some cultural factors can act as protective factors. For example, in a study with Taiwanese women, Hou, Ko, and Shu (2013) argue that positive community attitudes and leadership about the public obligation to assist survivors of abuse can support personal strength. Similarly, several studies report that an egalitarian culture between men and women helps survivors of IPV to be resilient (Hou et al., 2013; Rinfret-Raynor, Riou, Cantin, Droquin, & Dubé, 2004).

The Spanish Context

Prevalence of IPV in Spain is high. In the last macrosurvey carried out in 2011 (Women's Institute, 2012), 10.9% of the total number of female respondents said they had experienced gender violence at some time in their life. On the other hand, the results of different studies carried out in Spain show an estimated prevalence between 15 and 30% (Calvete et al., 2007; Fontanil et al., 2005; Ruiz-Pérez et al., 2010). However, there is a remarkable absence of studies on the resilience process in women who were survivors of IPV in Spain, although, as described below, some characteristics in the Spanish society may affect the way survivors build resilience.

In recent years, the government of Spain has implemented massive sensitization campaigns about the problem of violence against women, and many prevention and intervention programs have been developed (Roggeband, 2012). The development of the Organic Law 1/2004 of Integrated Protection Measures against Gender Violence was an important step with great social and legal implications against gender violence. The main purpose of this law is to provide a comprehensive and multidisciplinary response to gender violence by setting out measures of various kinds, such as educational measures, sensitization campaigns, social, economic, and legal measures. A novel feature included in this law is that it defines domestic violence as violence inflicted on women because of their status as women.

However, despite the efforts of the government of Spain, some features of the Spanish culture could be hindering the process of resilience of female survivors of IPV. For instance, Spanish society has been described as more collectivist than other western countries (Oyserman, Coon, & Kemmelmeier, 2002). Spaniards grant importance to the family and to maintaining close and positive relationships among family members (Rokach, Moya, Orzeck, & Exposito, 2001). Furthermore, Spanish society has been described as high in machismo, with a high rate of beliefs in women's inferiority (Echeburúa & Fernández-Montalvo, 2009), victim-blaming attitudes, and romantic love myths (Echeburúa, 2004). These myths imply believing that breaking up with one's partner is a personal failure or that some abusive behaviors are indicators of love (Bosch & Ferrer, 2002). In this sense, the Latino culture is very similar to the Spanish one, because the Latino culture has traditionally been considered collectivist (Campos et al., 2008) and high in machismo (Glass & Owen, 2010). These features of Spanish culture could influence the resilience process. For instance, the findings of a study conducted with Australian and Mongolian women showed that the women who lived in more collectivist cultures showed more resilience (Oke, 2008). In contrast, some studies conducted with Latinas have found that cultures that confer excessive importance to the family unit and that promote women's self-sacrifice hinder these women's resilience process (Campos et al., 2008; Roditti et al., 2010). Finally, a study with Chinese women indicated that victim-blaming attitudes can lead to secondary victimization of women, which in turn can perpetuate the cycle of violence (Tang et al., 2002).

Overview of the Present Study

The goal of the present study is to examine the resilience process of women who experienced IPV in Spain through their protagonists' narrations. More specifically, we intended to identify several protective factors that help survivors to build resilience, as well as the dynamics among these factors. Furthermore, we aim to compare the differences in the process of resilience among women who had recovered and those who had not recovered from partner abuse. The identification of these factors and their dynamics will contribute to the development of intervention strategies to more effectively help women who have experienced abuse.

Method

Study Design

Because of the limited research in Spain on resilience in survivors of abuse, we decided that a qualitative investigation design would be an adequate approach to the problem. Furthermore, a qualitative approach will allow for an in-depth and nuanced examination of the cultural context to which a quantitative approach would not be as sensitive. For this purpose, we carried out individual semistructured interviews with female survivors of IPV. The sample was divided into recovered and unrecovered women to compare the differences in the process of resilience between both groups. The criterion to divide the women into two groups was the presence or absence of symptoms associated with the abuse. According to the clinicians who assessed the women, before starting

therapy, all the women in the study displayed clinical symptoms of depression or PTSD or both, and this was the reason for the therapy. After therapy, recovered women were selected by their clinical psychologist for not having clinically relevant depressive or posttraumatic stress symptoms according to the *Diagnostic and Statistical Manual of Mental Disorders IV-TR (DSM-IV-TR;* American Psychiatric Association [APA], 2002). To assess these symptoms, their clinical psychologist used the Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996) and the Scale of Severity of Symptoms of Posttraumatic Stress Disorder (EGS-TEPT; Echeburúa, Corral, Amor, Zubizarreta, & Sarasua, 1997). The cutoff score was 10 on the BDI-II and 15 on the EGS-TEPT. According to the definition of recovery of Bellack (2006), women were considered to be recovered when the symptoms associated with partner abuse had remitted. On the other hand, women were considered unrecovered when they presented symptoms of depression or posttraumatic stress or both at a clinical or subclinical level.

Participants

To be able to form part of the sample, it was necessary for the women to have left the abusive relationship at the time of the interview. This inclusion criterion was established because we assumed that for women to begin to recover, they must have left the abusive relationship (Anderson & Saunders, 2003; Kernic, Holt, Stoner, Wolf, & Rivara, 2003; Zlotnick, Johnson, & Kohn, 2006). The abusive relationships experienced by women included a range of physical, sexual, and emotional maltreatment by their partners to gain or maintain power and control or authority over the women (American Psychological Association [APA], 2002).

The unrecovered group of women was made up of 10 women between 32 and 62 years of age ($M = 45.50$, $SD = 9.51$). All the women in this group had experienced physical and psychological violence in a couple relationship, except for one who had suffered sexual and psychological violence. Five of the women were married to their partner, four had had a couple relationship with cohabitation but had not married, and one of them had had a couple relationship with neither cohabitation nor marriage. Of all the women in this group, two of them had been involved in two abusive relationships, whereas the rest had been involved in a single relationship of this type. The women entered the abusive relationship at a mean age of 25.6 years ($SD = 5.06$) and the abusive relationship lasted for an average of 14.73 years ($SD = 12.38$). At the time of the interview, the mean number of years since leaving the abusive relationship was 1.67 years ($SD = 0.87$).

All the women were Spanish, except for two who were Latin American. Regarding educational level, four of the women had elementary studies, two had studied professional training, and four of them had university studies. Of the 10 women who made up this group, five of them had full-time jobs at the time of the interview, and five were unemployed. All of them had offspring (between 1 and 5 children). Of the 10 women interviewed, three were receiving individual therapy, and seven were receiving individual and group therapy.

The second group (recovered group) was made up of 12 women with ages between 25 and 60 years ($M = 47.25$, $SD = 11.60$). All the women had experienced both physical and psychological violence in a couple relationship, and four of the women had also suffered sexual violence. Eight of the women had been married to

their partner, three had had a couple relationship with cohabitation but had not married, and one of them had had a couple relationship with neither cohabitation nor marriage. All the women of this group had had a single abusive relationship, except for one of the participants, who had experienced two relationships of this type. The women initiated the abusive relationship at a mean age of 21.8 years ($SD = 5.55$) and the abusive relationship lasted for an average of 20.27 years ($SD = 11.73$). At the time of the interview, the mean number of years since leaving the abusive relationship was 4.58 years ($SD = 1.78$).

With regard to the sociodemographic data, one of the women was Latin American and the rest were Spanish. Three of the women had elementary studies, five had studied professional training, and four of them had university studies. According to the employment status, five of the women worked full time with a labor contract, four of them work by the hour without a contract, two women were unemployed, and one of them was preretired because of an occupational disability as a sequelae of the abuse experienced. With regard to the number of offspring, two of the women had no children, and the rest had between one and three children. All the women had undergone individual and group therapy.

Procedure

The interviews were conducted with women who were attending or who had attended centers that offer services to this group of women. First, the first author contacted the directors of two centers to obtain their collaboration. The center users were informed about the study by their therapist, who also gave them a letter with information about the study and the investigator's data, so that the women who were interested in participating would contact the investigator by telephone. None of the women who received the letter refused to participate. The women contacted the first author and an appointment was made for the interview. We offered to conduct the interviews in special rooms equipped for these purposes at the University of Deusto in the center where they received specialized services, or in their own homes. The interviews were carried out by two professionals from the field of violence against women: a psychologist (the first author) and a social worker who collaborated with the research team.

Data collection was carried out following the principles of theoretical sampling and saturation. Theoretical sampling aims to refine the theoretical ideas rather than to increase the size of the sample (Charmaz, 2000). Theoretical saturation, in contrast, implies that data are collected until there are no new important facts emerging within a category and until relations between the categories are well established (Strauss & Corbin, 1998). We reached saturation after performing 22 interviews.

The interviews took place between February 2012 and June 2013, and each interview lasted approximately 60–120 min. All the interviews were audio-taped for subsequent analysis. To protect participants' anonymity, a pseudonym was used for each participant. Likewise, before starting the interview, all the women signed an informed consent form. Each woman was given a 20€ check as a reward. All the interviews were transcribed by the first author. The ethical committee of the University of Deusto approved the study.

The researchers did not use any preexisting instrument because this could influence the participants' responses. Conversely, the interview began with an open question: "Tell me what happened when you left your abusive partner." If women mentioned aspects related to the process of resilience when answering this question, the researchers asked new questions. For example, if a participant explained that one of her first steps was to attend a course on writing and that this had helped her to "get back on her feet," the researcher would ask how this had helped her. In addition, and in accordance with grounded theory, as the data were analyzed, new aspects were incorporated into the interview. For example, the women talked about the importance of the family in the Spanish society and how the responsibility is attributed to the victim, and how this negatively influenced their resilience process. This prompted emergent possibilities of potentially larger sequential patterns in the participants' experience. Therefore, if in the next interviews, the women did not mention this topic spontaneously, they were asked about it.

Data Analysis

First, all the interviews were transcribed using the Transana 2.40 program (Fassnacht & Woods, 2009). We analyzed the interview data based on Strauss and Corbin's (1998) three levels of data analysis: open, axial, and selective coding. As a first step and after having transliterated each interview, we used open coding. For this purpose, expressions were classified by their units of meaning to assign concepts or codes to them. Open coding has been applied in varying degrees of detail, sometimes using line-by-line, sentence-by-sentence, or paragraph-by-paragraph analysis. As recommended by Flick (2014), line-by-line analysis has been used in particularly instructive or, conversely, confusing passages. For example, Ana (unrecovered group) says: "Above all, I began to feel better when I started to understand why the abuse occurred. It's like when you have all pieces of a puzzle. I have started it to put it all together, I have understood it." Codes derived from this story are: "explore the causes"; "understand the causes"; "multi-causal explanation"; and "relate the causes to each other." These codes were categorized by grouping them around phenomena discovered in the data, which are particularly relevant to the research question.

Data collection and analysis were alternated in constant comparison whereby theory emerging inductively from the data was compared deductively with new data to clarify and refine developing conceptual frameworks. The initial approach was as atheoretical as possible with a full literature review delayed until several initial interviews had been analyzed and theory was beginning to emerge. During the last phase of the analysis, the literature became a data source for ongoing comparison with emerging theory.

The next step was to refine and differentiate the categories derived from the open coding. From all the categories elaborated, we selected the most promising for further elaboration. We used axial coding to identify patterns of relationships. To formulate these relationships, we used the coding paradigm proposed by Strauss and Corbin (1998) of conditions, context, strategies (action/interaction), and consequences. We verified the relations elaborated and the categories over and over, comparing the text to the data.

The last step began when all the interviews were completed. Using selective coding, we assigned a core category in which all the categories were included. In the process of identifying the core category, we were attempting to discover what had occurred in the lives of the women after they had left the abusive relationship, and what process had they followed to achieve a positive adaptation within a context of significant adversity. Once the central phenomenon was chosen, categories and subcategories were interwoven to develop a coherent theory. After formulating the theory, we went back to verify it with the data.

Finally, to ensure the integrity and validity of the data, in addition to using the constant comparative method described above, we also used peer examination of the analysis. Throughout the entire encoding process, discussions with researchers in the field of IPV and resilience were conducted. Codes and emerging theory were extensively discussed and further refined in research meetings. Thus, from the onset of coding through the development of the grounded theory, we analyzed the data collaboratively.

Results

Figure 1 presents the model of resilience in survivors of IPV generated by the grounded theory. This is a general model that can be used for recovered and unrecovered women. The factors used by the women in the resilience process were categorized as individual and external.

As reflected in the interviews, resilient response to IPV is a dynamic process that occurs over time and that involves different factors of resilience that can be individual or external. These ideas are reflected at different times of the interviews. For example, Anne (unrecovered group) indicated that it consists of a process: "It has been a rewarding process," Maria (recovered group) ex-

plains that "it is an issue that emerges gradually" and Julia (unrecovered group) refers the fact that different factors act in the process of resilience: "It has been an accumulation of things."

Furthermore, resilience is a complex process because several factors are interrelated in a way in which the factors influence each other mutually. In this sense, Esperanza (recovered group) states that by means of creativity, in this case writing, she could increase her capacity for introspection: "I love to write, and writing has allowed me to increase the knowledge I had of myself." However, it is important to underline that not all the women employ the same resilience factors, and that the interplay between factors varies from one woman to the next. It is therefore difficult to establish fixed patterns of mechanisms between the different factors. The following sections describe the social context characteristics that, according to women's stories, have interfered with their process of resilience, and the individual and external factors as well as their dynamics and interrelations.

The Influence of the Social Context in the Resilience Process

Throughout the interviews, the women highlighted the importance of certain social and cultural aspects that have hindered them in the resilience process. First, the importance of the family for the Spanish culture became patent in the interviews carried out. For example, Sofia (unrecovered group) stated that in Spain: "People consider the family like a merging of the father, the mother, and the children. This has made my process more difficult."

On the other hand, in the Spanish culture, the victim is often held responsible for the maltreatment experienced. In this sense, Sofia (unrecovered group) explains: "When you go to the services for victims, you are treated as if you were sick, as if you had some

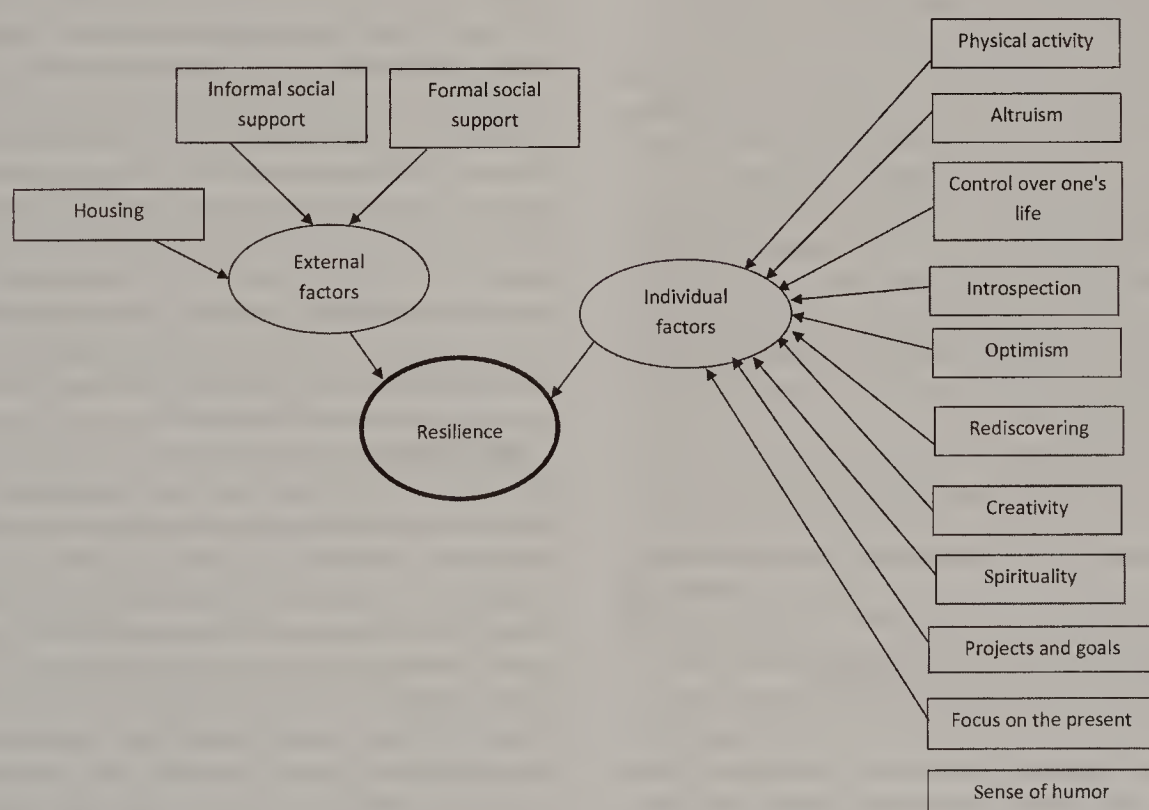


Figure 1. Resilience model in abused women.

disability. That's what I feel." Much more clearly, Julia (unrecovered group) declares: "Society points you out as if you were guilty."

In addition, a recurring theme during the interviews is the lack of adequate social resources to cope with the abuse of women. Women attribute this lack of response to the fact that society does not know how to behave when faced by a real situation of women's abuse. For example, Lorena (recovered group) states that:

I think that the awareness in society is real, but then society does not act. When a woman says that she is suffering abuse, perhaps at a certain time, she may need the police to accompany her, but this step is not taken, not even by her friends.

Finally, another recurring theme in the interviews is the level of awareness of Spanish society about IPV. Ten of the women claim that Spanish society is becoming increasingly aware and sensitized toward gender violence, but there is still a long way to go. In this sense, Yani (recovered group) says that "society is more concerned about the problem. There is still much to be done but I think that society is more aware."

Resilience Factors: Descriptions, Dynamics, and Relationships Among Them

Individual resources associated with resilience.

Physical activity. The interviewees described physical activity as a factor that had helped them to become acquainted with their bodies or that had brought them into contact with their bodies, thereby contributing to the development of feelings of well-being. Some of the activities mentioned by the women were walking, yoga, jogging, skiing, bicycling, and dancing. Marta (recovered group) explains the importance of physical activity in her resilience process as follows: "I began doing sports at the gym (. . .) and I finally decided to do belly dancing, going every day and evolving helps your self-esteem because, in the end, everything is related." For Adela (unrecovered group), physical activity was also an important resilience factor: "I like to run because when I run, I feel a release (. . .) I like sports very much, I feel calm."

Rediscovering oneself. This factor refers to the capacity to get to know oneself and to discover one's desires and skills. It is described by the women as a beautiful and pleasant process. Esperanza (recovered group) describes this feeling of rediscovery as follows: "I wanted to break away from everything. Ever since that year, for me, that date is my birthday, not when I was born: a way to rediscover myself."

Marta (recovered group) goes beyond this and explains that, in her case, the process involved changes in her person:

Well, after 16 years, I didn't even remember the way I used to be (. . .) You are reborn and, in the end, you are no longer the person he [the ex-partner] was with, because you are different afterward; you do not behave the same, you do not speak the same, and you are much happier. The truth is that I created another Marta.

Moreover, this factor is also influenced by other individual resilience factors that help them to discover new facets of themselves. Such is the case of Irene (unrecovered group), who, in her interview, explained that "physical activity allowed her to realize that she was a born athlete."

Altruism. A few participants of the study were highly involved in helping to eradicate gender violence. The following extract from the interview of Esperanza (recovered group) is a good example of altruism:

I get involved in everything I can to combat gender violence. In fact, I have spent the past 3 years holding recitals against gender violence. I also go to meetings to help other victims and I collaborate on a lot of projects.

This factor is infrequent in the women in the sample, especially in the group of unrecovered women. This suggests that for women to be able to mobilize this factor, it may be necessary for them to have reached a certain point in the resilience process. An example of this is Irene (unrecovered group), who states that "for the time being, I am not ready to help anyone."

Control over one's life. Women define control over one's life as a feeling of freedom or of being the owner of one's life. In addition, this factor is related to economic independence and, by extension, to work, as it is another way of feeling independent. Esther (recovered group) expressed it as follows:

Opening the closet and deciding what I'm going to wear today (. . .) That is the kind of things that make you say, 'I'm the owner of my life, I'm the owner of my life, and nobody is going to forbid me to dress the way I want to.'

Another interviewee, Maria (recovered group), explains the dynamic quality of this factor, because, initially, because of the aftermath of IPV, it is not possible to display this factor: "Control is something that comes along, but it takes you long time."

Creativity. The women of the sample developed creativity in diverse ways, for example, through writing, drawing, theater, and handicrafts. Many participants use creativity as a means to express their emotions. Laura (unrecovered group) explains it as follows: "I feel such a release when I draw (. . .) I focus so much on it that I do not think about anything else." Esperanza (recovered group) develops her creativity through writing: "I flood my writing with thoughts, emotions, certain moments, joy, and sadness."

In diverse interviews, this factor has been associated with the capacity of introspection, allowing it to increase through creative activities. As mentioned above, this is the case of Esperanza (recovered group). Also for Clara (recovered group), creativity helped her to mobilize the introspective factor: "I would walk for a long time and when I felt like it, I would sit down and write how I felt. Sometimes I would cry a lot. I would even draw, especially trees and birds flying. And these drawings and texts would allow me to explore myself internally."

Spirituality. This factor can be linked to a specific religion although, in most cases, the women do not identify with any particular religion. For example, Maria (recovered group) states that: "I have held on to my belief in God (. . .), I have felt His presence. Sometimes, I feel that I am special to Him." We note that some of the women reach spirituality through creativity. For example, Laura (unrecovered group) paints mandalas creatively. For Laura, mandalas are symbolic spiritual representations, and, as she explains, "When you paint mandalas, you can escape and get to another spiritual plane." Similarly, Clara (recovered group) expressed that: "painting pictures has allowed me to go from the more material and physical plane to a more energetic and spiritual plane."

Focus on the present. This factor changes over the long resilience process, because initially, after leaving the abusive relationship, some women explain that they just try to get through their everyday life and focus on living in the present. This is seen in Marta (recovered group), who explains that: “at the beginning, every day you fight to get by (. . .) I had to pay I for everything because he wouldn’t pay anything, so at that time, I could not enjoy everyday life.” This is very possibly because, after leaving the abusive relationship, women lose important material resources and must cope with new situations. However, when the women are at a more advanced point in the resilience process, this factor acquires another meaning and the interviewed women describe this factor as the skill of knowing how to live and to enjoy life day by day. The women explain that having experienced an abusive relationship and having lived in fear of death has taught them how to enjoy the present. Maria (recovered group) expresses it as follows: “Yesterday is gone and tomorrow doesn’t exist, the present is today. I have to learn to live today, to enjoy today because I have a lot of things going for me.” Lastly, this factor is not interrelated with any other factor in any of the interviews carried out.

Sense of humor. The participants conceptualize a sense of humor as the capacity to find the funny side of tragedy. A clear example of a sense of humor is seen in Anne (recovered group), who underlines its use within the framework of group therapy:

Just as we sometimes cried, sometimes we just had to laugh. That is, I have a sense of humor, and in the end, I laugh at all those things because it helps me. I am the kind of person who is the first one to laugh when I fall down.

As with the other factors, a sense of humor is a factor that develops over time. In this sense, Julia (unrecovered group) says: “A sense of humor emerges little by little.”

Introspection. The participants define this factor as knowing how to explore oneself internally, asking difficult questions and giving honest answers. However, they also admit the difficulty involved in developing this quality. Moreover, for many of these women, the work of introspection means going back to some aspects of their childhood. Such is the case of Esther (recovered group): “I did some introspection, going back to when I was little. I know the origin of the maltreatment: it is the relationship I have always had with my mother.”

However, introspection also includes understanding why violence occurred and reattributing responsibility. A clear example of this is displayed in Julia’s story (unrecovered group): “During the abusive relationship, you give way to the abuser, and little by little, he robs you of your ideas. There is no dialogue, no freedom for you to express your opinion. Then, you get into a [vicious] circle.”

The main activity that helped women to explore themselves internally was therapy. However, two activities emerged that also helped them in this task: reading books of self-knowledge and/or metaphysics and watching inspiring TV programs. This factor is of utmost importance within the process because it allows women to realize that their identities had been fragmented in the relationship, which leads to a process of integration that permits them to rediscover themselves. Thus, in some women, the introspection factor promotes the onset of the factor of rediscovery. However, this does not happen in all cases. For example, in Julia (unrecovered group), the factor of rediscovery emerges without a process of

introspection having taken place. This is probably because Julia has managed to carry out this process of integration that has allowed her to rediscover herself through the factor control over one’s life:

Thank to gaining control over my life, I could make decisions, and this has allowed me to know who I am and where I want to go in life. I have been able to reestablish contact with myself.

Julia’s abusive relationship involved her ex-partner’s strong control over her and her life. This quite possibly explains why, for this woman, rediscovering herself occurred through the factor of control over one’s life, rather than through introspection. In contrast, Irene (unrecovered group) has carried out a hard process of introspection without its having promoted the rediscovery factor.

Optimism. For these women, optimism is the capacity to find the positive side of situations and the tendency to expect good results in the future. Ana (recovered group) explains this tendency very clearly as follows: “I am optimistic, so I always think that when something very bad happens to you, something good must happen later on.”

As with other resilience factors, optimism is a skill that develops and, although initially after leaving the abusive relationship, women do not possess this factor, they are capable of developing it. For example, this is the case of Cristina (unrecovered group):

At the beginning, you are not optimistic and you need to program yourself to be positive, but one day, you suddenly realize that it comes naturally, and that you are an optimistic person.

In some women, informal social support, more specifically friendships and family, led them to developing a more optimistic view of life. Esther (recovered group) explains that:

There was one person who was essential for me. When I met her, I was really down, and she taught me many things. Especially, to be optimistic, for example, if I fall down, it may be because later on I am going to be hit by a truck and I had to fall at that time.

In the case of Adriana (recovered group), her daughter helped her develop the factor optimism: “My daughter’s seeing the good side of things has rubbed off on me, she has taught me.”

Projects and goals. In spite of the fact that the women underline the importance of living in the present, having goals and dreams also seems to be an important factor. In her discourse, Maria (recovered group) talks about the importance for her of having a project: “The important thing is to have a project because that is the essence of life (. . .) I see myself as a person who still has a lot of things to do.” However, as with the factor focus on the present, it is necessary to have previously resolved some aspects with their ex-partners (such as selling the home, trials, etc.). For example, Marta (recovered group) expresses the following: “First resolve whatever you have with him, this is a must to be able to set goals.”

External resources associated with resilience.

Housing. The role of housing is described by the women as something that goes beyond the material, because it has allowed them to feel safe and free of violence. The words of Esther (recovered group) exemplify this factor very well: “In my home, nothing bad would happen to me, it was like being in a safe bunker. I was not at all afraid that anything bad would happen.”

Besides, having their own home has helped the women to develop the factor of control over one's life. In this sense, Esther (recovered group) says, "To be able to be in your own home and put your socks on over your pajamas when you feel like it, and no one to criticize you. When this kind of thing happens, you realize that you are the owner of your life and that you control your life."

Informal social support. Two important sources emerged: on the one hand, the family, and on the other, friendships. Moreover, social support can be emotional or instrumental: "The most important support is that of a female friend (. . .); she has been like a sister to me. Friends help more than close family members." (Marina, unrecovered group).

Moreover, informal social support plays an important role within the resilience process because it helps to promote other factors. This is the case of Maria (recovered group), who, thanks to her daughter's support, began to practice aerobics, thereby mobilizing the factor of physical activity. We also underline that, in her narrative, informal social support acted as a springboard that is necessary for the women in the beginning, but later on, it is no longer necessary for them to continue using the factors that it initially mobilized:

I began to practice aerobics with my daughter in the gym. She practiced for a year and then said she was going to quit, but I decided to continue. It was hard because I had to do it alone, but with perseverance, I managed to do it.

Formal social support. With regard to formal social support, all the women rated group therapy very positively. The women also underline the services provided by the police, the mental health services, and juridical aspects. In this sense, the case of Adriana (recovered group) is noteworthy. She tells about the help she received from the police:

He told me, 'O.K., Ma'am, sit down here, let's see (. . .) I have three children of my own and I cannot just go home to my three children and let something bad happen to you. Don't you see that if you do not file a complaint, it's as though he were right?'

Group therapy deserves special mention as a source of formal social support, because all the women who had received it expressed this idea. Irene (unrecovered group), for example, values group therapy because it is a space in which the women can talk about their personal experiences without feeling judged:

You don't have to tell them anything because they already know it, and you feel freer. You're there like in some kind of group and if you feel like telling them about it, you do so, and if not, you don't, it doesn't matter.

In addition, formal social support is interrelated with two other factors. On the one hand, formal social support, especially the group therapy, is interrelated with the introspection process. For instance, as reported by the women, the participants in the group therapy identify with each other and this helped them to develop introspection. Lorena (recovered group) explains how, by means of therapy, she was able to perform introspection: "And it was important to have the chance to know myself better through group therapy." Furthermore, formal social support can lead to informal social support, because in some cases, the women who participate in the same group therapy become friends. This relation is reflected in Clara's (recovered group) story: "Thanks to the therapy,

I have made new friends. And these friends appeared at a very special moment, we have undergone the same things, and so, it is a strong friendship even if it is recent." Similarly, Mary (recovered group) explains that: "after the group therapy, they all went to have coffee together, enabling them to initiate friendships."

Comparisons Between Groups

With regard to the group comparison of recovered and unrecovered women, we underline that, although all the women use protective factors, the unrecovered women employed a smaller number of individual factors. For example, the average number of individual factors in the recovered group was 6.7, whereas in the unrecovered group, the average number of these factors was 4.5. However, with regard to external factors (housing and formal and informal social supports), no differences emerged between the two groups. It is also important to highlight that in the group of unrecovered women, there is less interplay between the resilience factors, both individual and external. Specifically, in the recovered group, the mean was 4.3, whereas in the unrecovered group, the mean was 1.5, and in three women, no relation between factors was observed. Table 1 presents the comparison of the group of recovered and unrecovered women with regard to the presence of individual and external resilience factors.

As Table 1 displays, the greater differences between the two groups are found in the factors of physical activity and altruism, the presence of which is much higher in the group of recovered women. With regard to the sociodemographic characteristics, employment status plays an important role, as the number of unemployed women is higher in the group of unrecovered women. Moreover, the fact of having a job seems more important than the work conditions because, in the recovered group, four of them do not have a work contract. On the other hand, according to the characteristics of the abusive relationship (duration of the relationship, relationship status, how old they were when they became involved in the violent relationship, etc.), no group differences were found. Nevertheless, there is an important difference between

Table 1. *Comparisons Between Recovered and Unrecovered Groups*

Recovered women	Unrecovered women
Individual factors	
Physical activity (9/12)	Physical activity (2/10)
Altruism (9/12)	Altruism (1/10)
Control over one's life (8/12)	Control over one's life (7/10)
Introspection (8/12)	Introspection (5/10)
Optimism (8/12)	Optimism (4/10)
Rediscovering oneself (8/12)	Rediscovering oneself (5/10)
Creativity (5/12)	Creativity (2/10)
Spirituality (6/12)	Spirituality (3/10)
Focus on the present (7/12)	Focus on the present (4/10)
Sense of humor (8/12)	Sense of humor (6/10)
Projects and goals (5/12)	Projects and goals (3/10)
External factors	
Informal social support (12/12)	Informal social support (10/10)
Formal social support (12/12)	Formal social support (10/10)
Housing (5/12)	Housing (3/10)

the two groups regarding the time since leaving the abusive relationship, as more time had gone by in the group of recovered women.

Lastly, in their stories, the unrecovered women refer to the fact that they had not yet reached a certain point in their recovery process, or that they were working on several aspects at the time of the interview. This kind of verbalizations did not emerge in the recovered group. For example, when asking Irene (unrecovered group) about the rediscovering factor, she explained that: "I don't think I'm at that phase yet."

Discussion

The results of this study are encouraging, as they highlight that women can develop resilience after leaving a violent relationship. Despite the high risk of various disorders related to maltreatment, such as PTSD and depression (Graham-Bermann et al., 2011; Macy et al., 2013), at the time of the interview, none of the 12 women in the recovered group presented clinical or subclinical symptoms associated with abuse, and all of them showed a resilient response.

In addition, the study reveals that the recovered and the unrecovered women used varied factors of resilience. Nevertheless, although no differences emerged between the two groups in the use of external factors, the recovered women had employed a higher mean number of individual resilience factors. This may indicate that, at the beginning of the process, women use external factors as a source of resilience, and only when the process has advanced are they prepared to develop and mobilize personal factors. Moreover, formal and informal social support has the capacity of promoting a large number of personal factors, which supports the aforementioned idea that they play a very relevant role in the resilience process, especially at the beginning. Various studies (Dowrick et al., 2008; Las Hayas et al., 2014; Torgalsbøen, 2012) have shown that there is an association between people's level of resilience and their ability to recover from the psychological aftermath of various traumas. Because of its cross-sectional nature, this study does not allow the establishment of a predictive association between the women's prior level of resilience and their recovery or nonrecovery from the sequelae of abuse. However, the fact that the recovered women use a greater number of personal factors and describe more reciprocal influence between the factors indicates that, just as with other adversities, people who recover from adversity or trauma have higher levels of resiliency than people who do not recover.

On the other hand, in terms of sociodemographic characteristics, the only difference found between the two groups was employment status, as the number of working women was higher in the group of recovered women. This factor may play an important role in the process of women's resilience because working can lead to developing resilience factors. For example, meeting new people in the work environment can help women to expand their informal social support network. Similarly, work can help women to develop the factor of control over one's life, because this factor is related to economic independence.

Another aspect that could influence the difference between the two groups is the time elapsed since they left the abusive relationship. The recovered women may have recovered because more time had gone by since they left the abusive relationship, as well

as because of the effects of the therapy. Nevertheless, we should be cautious when analyzing this fact, because not only the time elapsed since they left the relationship is important, but individual differences also play an important role. A clear example of this is Pisces, who, despite having put an end to her relationship just 8 months ago, was capable of developing a large number of resiliency factors similar to the group of recovered women. As mentioned above, longitudinal research should examine these possibilities in the future.

On the other hand, findings suggest that resilience and recovery are differentiated constructs. Although all the women in the sample are resilient, not all of them are recovered. This is reflected in the fact that the unrecovered women, despite still showing symptoms associated with abuse, are able to give a resilient response in the face of adversity. Several authors have theoretically proposed that resilience is part of the recovery process, but with an individual and differentiated entity (Robertson & Cooper, 2013; Youssef & Luthans, 2007). However, no studies to date had empirically assessed whether resilience and recovery are different, though closely related, processes. Therefore, this study contributes to clarifying the relationship between the two constructs.

The Role of Individual and External Factors and Their Dynamics

The development and mobilization of individual and external factors is crucial for the survivors' resilience. Moreover, there is a high degree of consistency between the findings of this study and studies conducted in other countries. Namely, consistent with prior research (Critelli, 2012; Davis, 2002; Oke, 2008; Song & Shih, 2010; Taylor, 2004; Yick, 2008), spirituality, altruism, feelings of control over one's own life, creativity, sense of humor, introspection, optimism, having projects and goals, rediscovering oneself, housing, and formal and informal social supports are resilience factors employed by women who have suffered partner abuse across different cultures.

However, despite the universality of certain resilience factors, in this sample of Spanish women, two important factors have emerged in the development of the resilience that have not appeared in women from other countries. First, physical activity helped the survivors to get to know their bodies better and, through this contact with their bodies, they increased their self-esteem. Despite the lack of published studies reporting that this factor protects women who have experienced abuse from developing symptoms of psychological maladjustment, diverse studies have shown that physical activity is effective to reduce depressive and anxiety symptoms in the face of other types of adversity (Harris, Cronkite, & Moos, 2006; Ströhle, 2009). Second, focus on the present emerged in the interviews as a key factor in the resilience process. Despite the fact that in other studies, this factor does not appear as clearly, they allude to it indirectly. For instance, the results of various studies indicate that the capacity to let go of the past was important for women who have experienced IPV (Giles & Curren, 2007; Senter & Caldwell, 2002; Smith, 2003).

Besides, the relationships among resilience factors are complex and idiosyncratic, which makes it difficult to reach general conclusions. On the one hand, findings indicate that all the factors contribute to resilience holistically. On the other hand, and reinforcing the idea of idiosyncrasy, none of the personal factors in the

women is essential for the resilient response to take place and can vary from one woman to the other. As stated by Rutter (1987), the protector factors interact with each other producing different dynamics that lead to the resilient response.

The Importance of the Context

With regard to the Spanish cultural and social factors, the women of the sample do not see any real help from society, which is discrepant with the findings of the study carried out by the European Commission (1999), which indicated that Spanish society condemns violence against women. As explained by Bosch and Ferrer (2002), this may be because of the phenomenon of social desirability, so frequent in this type of surveys.

Despite the fact that the government of Spain has made significant efforts to arouse social sensitization to and awareness of this type of violence, there is still a long way to go before this translates into real actions by society when faced with women's abuse. According to the results of a study carried out by Latta and Goodman (2011), we are moving toward the consideration of partner violence against women as a social problem, for which the entire society is liable. However, the results of this study do not reflect this change, indicating that Spanish society has not yet reached this point.

Limitations and Future Lines of Research

This work presents some limitations that should be taken into account when interpreting the results. The main limitation is that all the women had received psychological therapy to some degree, and therefore, we were not able to study the process of resilience in women who had not received psychological therapy. This limitation makes it difficult to differentiate between recovery that is the result of the therapy or the result of resilience. Moreover, in spite of the fact that resilience implies interplay among protective factors and vulnerability (Olsson, Bond, Burns, Vella-Brodrick, & Sawyer, 2003), this study focused mainly on protective factors. As in studies that only focus on women's symptoms, this limitation may be providing a partial view of the recovery process of women who have experienced violence. Thus, future studies should examine the interplay between factors of vulnerability and resilience. Finally, the sample of this study does not represent the entire population of survivors of partner violence in Spain, so it is difficult to generalize the results found in this study.

The limitations of the study create opportunities for future studies. First, it is necessary to verify whether the resilience factors that emerged in this study can be generalized to samples of survivors in other cultures. Moreover, it is necessary to perform cross-cultural studies to explore the influence of culture in the resilience process of survivors of IPV. Similarly, it would be important to perform longitudinal studies to examine resilience as a process and identify which resilience factors predict recovery from psychological symptoms—and through which mechanisms (i.e., coping strategies). Despite the fact that the most widely accepted current definitions of resilience consider this concept as a process (Masten & Powell, 2003; Luthar, 2006), in practice, no longitudinal studies have been performed revealing the dynamic nature of resilience in women who have experienced IPV. There-

fore, future research should examine the resilience process in women who have experienced IPV over time. The association between resilience and other related concepts, such as posttraumatic growth, should be examined also. Finally, the role of focusing on the present and physical activity in women's resilience response to IPV should be explored in greater depth, because these factors did not appear in previous studies.

Clinical Implications

The results of this study have important clinical implications because they reveal the need to help women to develop and mobilize individual and external factors that promote resilience. For this purpose, in addition to the standard intervention techniques, other techniques could be employed. For example, Mindfulness training (Hofmann, Sawyer, Witt, & Oh, 2010), which emphasizes the present moment, could be used to help women to develop focus on the present. Likewise, physical activity should be included in the interventions with survivors of IPV. Sense of humor and optimism could also be promoted through laughter therapy, which has shown its efficacy to cope with diverse adversities in various studies (Ko & Youn, 2011; Mora-Ripoll, 2010). In view of clinical interventions, it would also be important to foster the factor control over one's life, as various authors defend can be done through empowerment (Busch & Valentine, 2000; Gengler, 2012).

Moreover, in interventions with female survivors of IPV, it is necessary to carry out activities that promote the factors of creativity, introspection, and spirituality. In general, experiential techniques such as meditation, art, imagination, and poetry can help women to develop these factors (Barrett, 2009; Kane, 2006). With regard to external factors, it is also necessary to provide facilities to women so they can achieve a home that they will feel is their own and safe, as well as a job. Lastly, formal and informal social support was shown to be a very beneficial factor for the women of this sample; therefore, interventions with this collective of women should promote and strengthen the social support network.

Conclusion

This study has contributed new data about the resilience process of women who have experienced abuse in our context. The idea that emerges is that women are capable of developing a resilient response in the face of abuse. Another noteworthy aspect is that there are many ways to carry out the resilience process because each woman used different ways or pathways; but in all cases, the goal is the same: resilience. The results show that this process is complex and that multiple factors come into play.

Keywords: domestic violence; intimate partner violence; resilience; protective factors

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The Relevance and Implications of Organizational Involvement for Serious Mental Illness Populations

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Consumer involvement has gained greater prominence in serious mental illness (SMI) because of the harmonious forces of new research findings, psychiatric rehabilitation, and the recovery movement. Previously conceived subdomains of consumer involvement include physical involvement, social involvement, and psychological involvement. We posit a fourth subdomain, organizational involvement. We have operationally defined organizational involvement as the involvement of mental health consumers in activities and organizations that are relevant to the mental health aspect of their identities from an individual to a systemic level across arenas relevant to mental health. This study surveyed adults with SMI regarding their current level of organizational involvement along with their preferences and beliefs about organizational involvement. Additionally, a path model was conducted to understand the relationships between domains of consumer involvement. Although participants reported wanting to be involved in identified organizational involvement activities and believing it was important to be involved in these kinds of activities, organizational involvement was low overall. The path model indicated that psychological involvement among other factors influence organizational involvement, which informed our suggestions to improve organizational involvement among people with SMI. Successful implementation must be a thoroughly consumer-centered approach creating meaningful and accessible involvement opportunities. Our study and prior studies indicate that organizational involvement and other subdomains of consumer involvement are key to the health and wellbeing of consumers, and therefore greater priority should be given to interventions aimed at increasing these essential domains.

The past three decades have witnessed a transformation in scientific understanding, clinical treatment, and social policy regarding disabling psychiatric disorders in the schizophrenia spectrum, also known by the administrative rubric of

serious mental illness (SMI).¹ Research has refuted the traditional downward prognosis for people with SMI, which had previously assumed that possibility of recovery was doubtful. Rather, it is becoming clear that people with SMI can benefit from treatment, and many regain most or all functional ability (e.g., Harding,

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¹In some venues, SMI and related terms have been used to denote different groups, including those who have any *Diagnostic and Statistical Manual of Mental Disorders* diagnosis. This practice undermines consistent discussion and development of social policy regarding severe and disabling disorders in the schizophrenia spectrum. Here, we use the Charlwood, Mason, Goldacre, Cleary, and Wilkinson (1999) definition of SMI, as a mental disorder designated by a mental health professional and either (a) a score of 4 (severe/very severe problem) on at least one, or a score of 3 (moderately severe problem) on at least two of the Health of the Nation Outcome Scale items excluding #5 during the previous 6 months, or (b) there must have been a significant level of service usage over the past 5 years as shown by a total of 6 months in a psychiatric ward or day hospital, or three admissions to hospital or day hospital, or 6 months of psychiatric community care involving more than one worker or the perceived need for such care if unavailable or refused.

Brooks, Ashikaga, Strauss, & Breier, 1987a, 1987b; Harding, Zubin, & Strauss, 1992; Jobe & Harrow, 2010; Stephens, 1978; Strauss & Carpenter, 1978). *Psychiatric rehabilitation* (e.g., Anthony, Buell, et al., 1972; Liberman, 2008; Spaulding, Sullivan, & Poland, 2003) has reconfigured understanding of mental illness from a disease to be cured to a disability to be overcome, and has produced an expanding array of effective clinical tools for that purpose. Parallel emergence of the *recovery movement* (e.g., Anthony, 1993; Deegan, 1988; Jacobson & Greenley, 2001) has further elucidated new goals and challenges for treatment and rehabilitation. These goals include focusing on positive sense of self, interpersonal relationships and participation in community life (e.g., Davidson & Strauss, 1992; Davidson et al., 2001), and new agendas for clinical research and social policy (Bellack, 2006).

The imperative of *involvement* is at the center of all three of these major trends (Davidson et al., 2001; Rutter, Manley, Weaver, Crawford, & Fulop, 2004). Although involvement evolved from the developmental disabilities field, it quickly became applied to other populations who experience difficulty integrating into typical communities and social networks. Most conceptualizations of involvement across populations emphasize that although physical presence in a person's desired community is important, true involvement could only be achieved through social integration, including culturally specific acceptance by community members.

Involvement has innate utility for SMI. It has a clear relationship to the imperatives of treatment modalities including psychiatric rehabilitation and consumer-led movements including recovery. Involvement focuses on increasing functioning and activity within an autonomous and empowered context. Involvement additionally prioritizes decreasing stigma and social segregation. Researchers and associated stakeholders developed *consumer involvement*, an umbrella term encompassing aspects of involvement that are most key to stakeholders and to treatment outcomes. This construct has implications across areas of interest, from advancing scientific understanding regarding resources needed to facilitate functional improvement in SMI populations to elucidating how to structure public policies so that SMI populations have the opportunity to improve involvement.

Three major aspects of consumer involvement have been identified: *physical involvement*, *social involvement*, and *psychological involvement* (Wong & Solomon, 2002). Physical involvement chiefly focuses on involvement in activities of daily living, a key aspect of independent functioning often targeted in skills training and other evidence based practices for SMI. Social involvement focuses on one-on-one and small group social interactions, which are often deficient in SMI populations because of impaired social skills and social isolation because of stigma and difficulty integrating into typical communities. Psychological involvement focuses on the subjective experience of being involved and accepted into one's chosen community, often lacking because of unstable living arrangements, isolation, and stigma. Interventions across these domains have clear treatment implications (e.g., improving skill sets) and policy implications (e.g., decreasing instability and stigma).

An essential subdomain of involvement to consider is involvement with organizations pertinent to mental health consumers. This domain, *organizational involvement*, includes involvement across levels of organization: individual aspects of organization like treatment planning and peer services, program aspects of

organization like program development and evaluation, system aspects of organization like advocacy and research, and policy aspects of organization like system-level policy planning and evaluation. The fundamental premise of this sort of involvement is to prioritize and recognize consumer worth, values, and needs at the organizational level and take congruent action with consumers in active and meaningful roles. Therefore organizational involvement adds a key element to the consumer involvement paradigm by prioritizing increases in autonomy and empowerment, and decreases in stigma at the systemic level. This encompasses many of the areas of participation particularly sought after by consumers and other stakeholders promoting the recovery movement, including client involvement in treatment planning (Deegan, 2007), consumer-run organizations and peer services (Brown, Shepherd, Merkle, Wituk, & Meissen, 2008; Schutt & Rogers, 2009).

Given calls by the recovery movement to increase empowerment, autonomy, and purpose, partially via involvement-related activities (Anthony, 1993; Brown et al., 2008), it is clear that mental health consumers value consumer involvement across domains. Despite the innate connection between recovery, community-based services, and consumer involvement, there is little research on involvement, its dimensions, or their relationships with other outcomes in SMI populations. Relevant to our article, there are no studies that we are aware of that measure practical availability or consumer awareness of involvement opportunities in the United States.

The majority of scholarly interest in consumer involvement has come from Australia and New Zealand. This appears to be partially because of increased policy focus on consumer involvement in both countries. This combination of increased policy focus and scholarly interest has led to increased interventions and other studies in this area (e.g., Happell & Roper, 2009; McCann, Baird, Clark, & Lu, 2008). These studies represent the beginnings of the implementation and study of consumer involvement and how it may impact consumers and mental health service systems. In other countries, including the United States, there are less scholarly works on consumer involvement despite increased policy focus on this area. We hope that our work can begin to expand our understandings of consumer involvement in the United States as the related regulatory processes are unfolding.

The research that does exist in the United States has generally focused on peer services, including consumer-operated services and peer support specialists (Brown et al., 2008; Corrigan, 2006). Doughty and Tse's (2011) review of peer services found that the majority of peer services are operated within a traditional mental health agency, with a minority operating independently. The review generally found that consumers benefited from working with typical treatment providers and with peers, although there was considerable variation across studies. Of course, the majority of studies used quite small sample sizes and there was appreciable heterogeneity between studies, including treatment modalities. These studies indicate that peer services are a promising area of consumer involvement, but continue to require development and study to maximize effectiveness.

Although peer services are important, they represent one aspect of one domain of consumer involvement, organizational involvement. Other key aspects of organizational involvement are rarely studied and implemented in the United States. As noted previously, Australian literature has a much wider array of literature regarding consumer involvement, including academia (Happell &

Roper, 2009), mental health administration and service planning (McCann et al., 2008), and program evaluation and quality improvement (Middleton, Stanton, & Renouf, 2004).

Across countries and areas of organizational involvement, consumers tend to report feeling positively about their organizational involvement experiences. Consumers also report positively influencing those around them, including nonconsumer staff (Middleton et al., 2004). Additionally, treatment providers often report feeling positively about organizational involvement (McCann et al., 2008), and as discussed previously, there is some evidence that organizational involvement can benefit consumers. Despite this, implementation of organizational involvement remains variable at best (Gordon, 2005; Tobin, Chen, & Leathley, 2002).

Prior studies have identified an array of barriers to successful implementation of organizational involvement. Mental health systems have been slow to adjust to new policies supporting consumer involvement, and often lack the resources needed to back these new policies. Additionally, when policies are adjusted to promote consumer involvement and increase community-based care, consumers are often not involved in making these policy decisions (Middleton et al., 2004), a process that undermines the goal of the policy. Both Tobin et al. (2002) and Middleton et al. (2004) identified the need to increase the amount of information, support, and resources available to consumers for consumer involvement policies to succeed. Although treatment providers and other stakeholders do report positive feelings about involvement, they also report not wanting consumers' responsibilities or influence to infringe on their own (McCann et al., 2008) and worrying that the "wrong" kind of consumer will be more likely to take on organizational involvement roles (Happell, 2010). Therefore, although consumer involvement has been a key component of many recent policy changes, as a result of a range of barriers, associated implementation and scholarly work is still in its infancy.

The Current Study

This study seeks to further understanding of the organizational involvement subdomain of consumer involvement. In particular, we are interested in the impact that a significant set of changes to mental health policy had on the SMI population, our target sample. The major component of these changes was downsizing the state hospital system by two thirds and transferring over 30 million dollars in state funding into community-based services (Division of Behavioral Health, 2011). A specific goal of these changes was to increase community-based services and consumer involvement through a variety of avenues. These avenues included the creation of a state-operated Office of Consumer Affairs, and a focus on consumer involvement in regional advisory boards, community agencies, and public policy (Division of Behavioral Health, 2011; Nebraska Behavioral Health Service Act, 2006). Of course, these changes did not occur in isolation. There have been movements federally (e.g., Olmstead v. LC, 1999; New Freedom Commission on Mental Health, 2003) and in other states (e.g., Kano, Willging, & Rylko-Bauer, 2009) to increase community-based services and focus on consumer involvement across domains.

The particular changes in the service area targeted created a unique opportunity to survey level of involvement in a theoretically enriched environment, as well as to understand the relationship between domains of involvement and their impact on con-

sumers. Therefore, this study captured consumer-reported levels of current organizational involvement and other subdomains of consumer involvement among people with SMI. This sample was receiving community-based services and would otherwise be at risk for institutionalization without these policy changes intended to improve involvement.

The guiding intention of this study was to better understand the relationship between dimensions of consumer involvement in this population and to guide future policy and service development. We primarily focused on breadth of consumer involvement domains, and attempted to capture all four theoretical domains: physical involvement, social involvement, psychological involvement, and organizational involvement. We measured all four domains to understand the mechanistic relationships between these domains in this population, and how other domains impact organizational involvement given policy changes. We also considered breadth of the organizational involvement domain in particular by measuring concrete levels of involvement as well as issues like consumer awareness, interest in specific activities, and values regarding involvement.

We hypothesized that organizational involvement would be low. We hypothesized that consumers would report little involvement in activities that have been made available to them through policy change via their service providers, their community, and at the state level. We additionally hypothesized that consumers would report wanting to be involved with activities that they were not currently involved in. Lastly, we hypothesized that other types of consumer involvement, and physical involvement in particular, would be significantly associated with organizational involvement.

Method

Participants

Two hundred sixty-six consumers currently attending state-funded day programs participated in the study. Consumers must be 19 or older and meet criteria for SMI to be eligible for these services. One hundred twenty-three (46.2%) of the participants were male. The average age of the participants was 44.77 ($SD = 11.478$). One hundred thirteen (42.5%) of the participants lived independently, and 40 (15%) reported being in a residential rehabilitation program. Fifty-eight (22.3%) of the participants reported being employed part-time or full-time, while 47 (18.5%) reported attending school part-time or full-time. Eighty-three (38.6%) of the participants reported being involved in volunteering. A more complete description of the participants' demographics is available in Table 1.

Measures

Organizational involvement was operationally defined as active involvement by mental health consumers in organizations or other systems directly related to the advocacy, planning, regulation, evaluation, or improvement of mental health services, research, or policies, impacting a spectrum of groups (i.e., from single individual to nationwide systems or groups). Based on this definition, the research team in conjunction with an advisory group consisting of mental health consumers and mental health advocates created an

Table 1. *Selected Demographic Information for Survey Participants*

Variable	<i>n</i>	%
Living status		
Living alone	113	42.5
Living with friends or relatives	77	28.9
Living in a home with 24-hr support	50	18.8
Living alone with support	10	3.8
Government-provided housing	4	1.5
Living in a shelter	2	0.8
Services currently received		
Day rehabilitation	210	78.9
Mental health counseling	161	60.5
Community support	104	39.1
Medication management	91	34.3
Residential rehabilitation	40	15.0
Vocational rehabilitation	17	6.4
Assertive community treatment	15	5.7
Highest level of education reached		
Less than high school	55	20.7
Graduated high school	97	36.5
Some college	72	27.1
2- or 4-year college grad	31	11.7
Post college education	8	3.0

organizational involvement measure tailored to activities that consumers in our target sample would be most likely to have access to. Once the organizational involvement measure was drafted, it was pilot tested among the consumer advisory group and the consumer research assistants associated with the study. The consumer advisory group members and consumer research assistants gave feedback on the measure. Their feedback was used to refine the measure before its use in data collection.

A list of seven activities was generated: being a member of an advisory committee for service providers or state agencies; developing services; evaluating services; being a member of an independent consumer action group including but not limited to the National Alliance on Mental Illness (NAMI) and the Mental Health Association (MHA); being a peer-review team member; and being involved with the state Office of Consumer Affairs (OCA), either directly or by participating in the town hall meetings offered by the OCA. Additionally, an "other" category was offered for participants to write in additional organizational involvement activities.

For each activity, participants were asked to endorse involvement across four levels. First, participants were asked whether they were aware that involvement opportunities existed for each activity, creating an *awareness of opportunities* variable. Second, participants were asked whether they had ever been invited to become involved or otherwise given an opportunity to become involved in each activity, creating an *invited to be involved* variable. Third, participants were asked whether they were involved with each of the activities, creating an *involvement* variable. Last, participants were asked whether they would like to become involved with each activity, creating a *desire to be involved* variable.

Two questions rating the importance of organization involvement were used to parse out the difference between quantitative current involvement and the value placed on organizational in-

volvement among the target population. First, participants were asked to rate on a 5-point Likert scale how personally important it was for them to be involved in the activities listed in the survey or other similar activities, creating a *personal importance* variable. Using the same scale, participants also rated how important they believed it was for consumers in general to be involved in these types of activities, creating a *group importance* variable.

Two additional measures were used to capture the three other subdomains of consumer involvement. Participants also completed the Community Integration Questionnaire (CIQ; Willer, Rosenthal, Kreutzer, Gordon, & Rempel, 1993) to evaluate physical and social involvement. The CIQ was initially constructed to measure community integration following brain injury, and a study comparing longitudinal scores of participants with traumatic brain injury and those with other disabling injuries suggest that the CIQ can be generalized to other populations (Corrigan & Deming, 1995). The measure has three factors, with favorable internal consistency: Cronbach's alpha equals .76 for home integration, .73 for social integration, and .84 for productivity (Willer et al., 1993).

Lastly, participants completed the Community Integration Measure (CIM; McColl, Davies, Carlson, Johnston, & Minnes, 2001) to evaluate psychological involvement. The CIM was originally constructed to measure community integration of consumers with brain injuries after they leave inpatient settings. However, researchers have used the measure successfully with SMI populations (Lloyd, Waghorn, Best, & Gemmell, 2008; Lloyd, King, & Moore, 2010). Internal consistency of the CIM among day rehabilitation users was favorable; Cronbach's alpha = .85 (Lloyd et al., 2008).

Procedure

Consumers attending community-based day programs completed surveys at 10 sites. The majority of participants (93.4%) completed the survey at their current day program; a minority of participants (6.6%) completed the survey in public libraries. Consumers were offered an incentive of a \$10 gift card. In an effort to promote organizational involvement via our study, we integrated principles of participatory action methodology (Baum, MacDougall, & Smith, 2006). Specifically, mental health consumers were hired as research assistants and invited to be on the advisory committee, and therefore were integral parts of the study process. This study received ethical approval from the Institutional Review Board at the University of Nebraska-Lincoln.

Data Analysis

To understand participants' current level of consumer involvement in the eight categories of organizational involvement activities used in the survey, first a total score of involvement was calculated for each participant for each of the four levels of involvement. Participants could have a total score ranging from 0 (if they checked "none of the above") to 8 (if they checked all of the activities) in each of the following categories: being aware of the activity (awareness of opportunities), being invited to be involved (invited to be involved), being involved in the activity (involvement), and wanting to be involved (desire to be involved). These totals were averaged across all participants. Additionally,

participants were asked how important they thought it was for them personally to be involved in these types of activities (personal importance), as well as how important it was for consumers as a whole to be involved (group importance). These totals were also averaged across all participants.

A path model using Mplus (Muthén & Muthén, 1998–2011) under robust maximum likelihood with Montecarlo integration was used to understand the mechanisms between three consumer involvement domains (psychological involvement, social involvement, and two physical involvement subdomains, productivity and home integration) and how they impact organizational involvement. This model was chosen to understand the relationships between different domains of consumer involvement, particularly in a theoretically enriched environment. Given the recent policy changes, we would expect that not only would organizational involvement increase, but other areas would as well. For instance, physical involvement should increase because of higher use of community-based services rather than inpatient services.

We hypothesized that feelings about involvement and community (e.g., psychological involvement) was a necessary precursor to involvement activities (e.g., social involvement), and therefore placed the former constructs at higher levels in the model. Additionally, we hypothesized that individual-level involvement (e.g., social involvement) was a precursor to system-level involvement (i.e., organizational involvement), and therefore again placed the former constructs at higher levels in the model.

Specifically, psychological involvement was used as a Level 1 effect to contextualize overarching beliefs about involvement, while physical involvement, social involvement, and organizational involvement beliefs were used as Level 2 effects to model daily involvement behaviors and beliefs. The four levels of organizational involvement were used as outcome variables. Robust maximum likelihood was used to account for non-normality and missing items, and Montecarlo integration was used to estimate categorical variables. The Auxiliary command was used to model a pattern of missingness using education level because some participants had difficulty during data collection caused by reading ability. The Model Constraint command was used to model the indirect effects.

Results

Reported Organizational Involvement

Overall, consumer involvement was low. The average amount of awareness of opportunities was 1.02, indicating that each participant was aware of approximately one of the eight involvement activities. The average amount of invited to be involved was 0.84, indicating that for every six participants, approximately five invitations to an involvement activity were reported. The average amount of involvement was 0.71, indicating that for every seven participants, involvement in approximately five activities was reported. The average amount of desire to be involved was 1.09, indicating that each participant wanted to be involved with about one of the eight involvement activities. Because of a lack of previous norms or other parameters, it was not possible to understand these results in greater context. Please see Figure 1 for a visual depiction of these results.

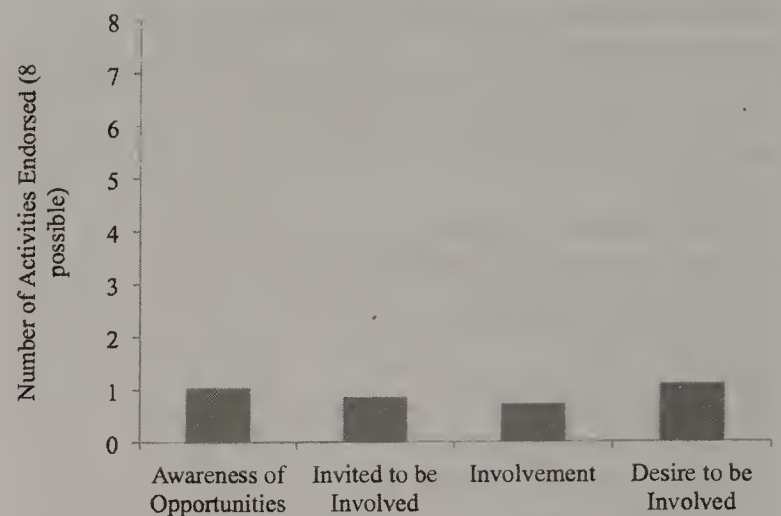


Figure 1. Visual depiction of average amount of involvement across intensities of involvement.

The amount of value participants placed on consumer involvement was high. The average amount of personal importance was 3.44 on a Likert scale from 1 (*not at all important*) to 5 (*extremely important*). The average amount of group importance was 3.84, measured on the same scale as personal importance. There was no difference between value placed on personal importance and group importance. Again, as there is no previous research in this area or using this measure, it is unclear whether these results are typical. Please see Figure 2 for a visual depiction of these results.

Comparisons Between Levels and Types of Organizational Involvement

There were no differences between types of organizational involvement. That is, participants did not report being more or less aware of opportunities than they were involved, and the same was true for all of the other possible comparisons. Table 2 is the covariance matrix between these variables. To understand these results further, each category of involvement was broken down by activity (see Table 3) and *t* test analyses were conducted to determine differences between participants' level of involvement by type of activity.

When comparing desire to be involved and involvement, more participants reported desiring to be involved in advisory committees, $t(251) = -3.042$, $p = .003$, service evaluation opportunities, $t(251) = -1.999$, $p = .047$, peer review teams, $t(251) = -3.761$, $p < .0001$, the OCA, $t(251) = -2.782$, $p = .006$, and service development opportunities, $t(251) = -4.731$, $p < .0001$ than reported being involved in those activities. Participants were more likely to want to be involved in these five activities than actually being involved in them.

When comparing desire to be involved and invited to be involved, more participants reported desiring to be involved in peer review teams, $t(251) = -2.815$, $p = .005$, the OCA, $t(251) = -3.331$, $p = .001$, and service development opportunities, $t(251) = -2.941$, $p = .004$ than reported being invited to be involved in those activities. Participants were more likely to want to be involved in these three activities than were invited to be involved with them.

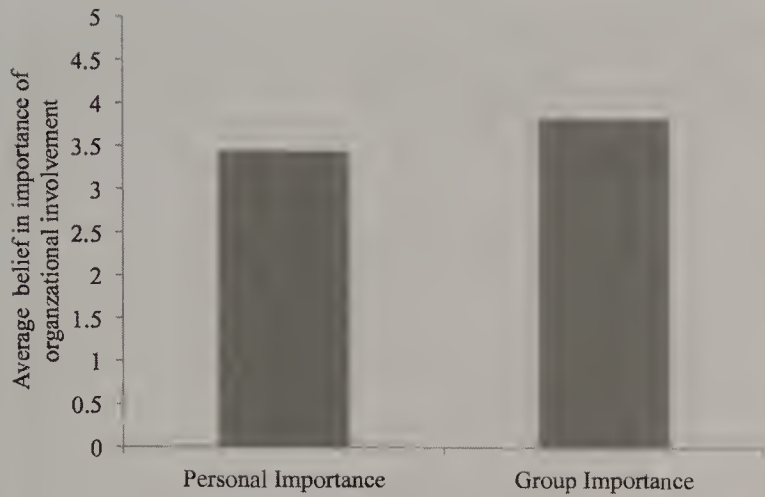


Figure 2. Visual depiction of average amount of beliefs regarding importance of organizational involvement.

When comparing desire to be involved and awareness of opportunities, more participants reported desiring to be involved in the OCA, $t(251) = -2.056$, $p = .041$ and service development opportunities, $t(251) = -2.453$, $p = .015$ than reported being aware of opportunities. Participants were more likely to want to be involved in these two activities than were previously aware that the activities existed.

When comparing involvement and invited to be involved, more participants reported being invited to be involved in advisory committees, $t(255) = 2.356$, $p = .019$, service development activities, $t(255) = 1.975$, $p = .049$, and independent consumer action groups, $t(255) = 3.768$, $p < .0001$ than reported being involved in those activities. Participants were more likely to have received an invitation to be involved in these three activities than were actually involved in them.

When comparing *involvement* and awareness of opportunities, more participants reported being *aware* of advisory committees, $t(254) = 3.529$, $p < .0001$, service evaluation activities, $t(254) = 4.364$, $p < .0001$, service development activities, $t(254) = 2.132$, $p = .034$, and independent consumer action groups, $t(254) = 3.744$, $p < .0001$ than reported being *involved* in those activities. Participants were more likely to be aware of these four activities than were actually involved in them.

When comparing invited to be involved and awareness of opportunities, more participants reported being *aware* of service evaluation activities, $t(254) = 2.748$, $p = .006$ and peer review team activities, $t(254) = 2.528$, $p = .012$ than reported being invited to be involved in those activities. Participants were more likely to be aware of these two activities than were invited to be involved in them.

There were no differences across levels of involvement for either town hall meetings or the "other" category, likely caused by the particularly low endorsement of those categories across levels.

These results showed that organizational involvement was low overall among our sample, although participants reported that organizational involvement is important to them. The results additionally showed some variability among levels and activities measured.

Path Model of Subdomains of Consumer Involvement on Current Organizational Involvement

To understand the mechanistic relationships between consumer involvement domains and how those domains impact organizational involvement, a path analysis was conducted. Figure 3 is a visual depiction of the final model.

First, analyses considering the effect of psychological involvement on Level 2 predictors found that psychological involvement significantly predicted social involvement ($\beta = .100$, $t = 3.861$, $p < .001$), home integration ($\beta = .112$, $t = 2.922$, $p = .003$), personal importance ($\beta = .627$, $t = 3.973$, $p < .001$) and group importance ($\beta = .781$, $t = 4.828$, $p < .001$).

Second, analyses considering the effect of psychological involvement on levels of organizational involvement found that psychological involvement did not directly significantly predict any level of organizational involvement, $p > .05$ for all analyses.

Third, analyses considering the effect of Level 2 predictors on levels of organizational involvement found several significant effects. Group importance ($\beta = .177$, $t = 32.280$, $p = .023$) significantly predicted awareness of opportunities. Social involvement ($\beta = .355$, $t = 1.990$, $p = .047$) and group importance ($\beta = .177$, $t = 2.642$, $p = .008$) significantly predicted invited to be involved. Personal importance ($\beta = .162$, $t = 2.350$, $p = .019$) significantly predicted involvement. Productivity ($\beta = .358$, $t = 2.008$, $p = .045$), group importance ($\beta = .271$, $t = 3.513$, $p < .001$) and personal importance ($\beta = .191$, $t = 2.469$, $p = .014$) significantly predicted desire to be involved.

Finally, analyses considering the indirect effect of *psychological involvement* on levels of organizational involvement via Level 2 effects found five significant effects. Psychological involvement had an indirect effect on levels of awareness of opportunities ($\beta = .138$, $t = 21.973$, $p = .049$), invited to be involved ($\beta = .138$, $t = 2.214$, $p = .027$), and desire to be involved ($\beta = .212$, $t = 2.669$, $p = .008$) via *group importance*. Additionally, psychological involvement had an indirect effect on involvement ($\beta = .102$, $t =$

Table 2. Covariance Matrix of Levels of Involvement

	Awareness of opportunities	Invited to be involved	Involvement	Desire to be involved
Awareness of opportunities	1.899	.921	.784	.575
Invited to be involved	.921	1.353	.878	.564
Involvement	.784	.878	1.256	.704
Desire to be involved	.575	.564	.704	2.464

Table 3. *Participants Endorsing Levels of Organizational Involvement by Activity*

Awareness	Advising committee	21.4%	Invited	Advising committee	18.4%
	Evaluation	25.2%		Evaluation	18.4%
	Peer review team	10.5%		Peer review team	7.5%
	OCA	4.5%		OCA	2.6%
	Service development	10.5%		Service development	9.6%
	Town hall meetings	5.6%		Town hall meetings	4.1%
	Independent consumer action groups	16.2%		Independent Consumer Action Groups	15.4%
	Other	3.4%		Other	2.6%
Involvement	Advising committee	13.5%	Desire	Advising committee	22.2%
	Evaluation	15.4%		Evaluation	21.8%
	Peer review team	5.6%		Peer review team	13.9%
	OCA	3.4%		OCA	8.6%
	Service development	6.4%		Service development	16.9%
	Town hall meetings	3.8%		Town hall meetings	5.3%
	Independent consumer action groups	8.6%		Independent consumer action groups	12.8%
	Other	3.4%		Other	3.8%

Note. OCA = Office of Consumer Affairs, which is state-run.

2.087, $p = .037$), and desire to be involved ($\beta = .120$, $t = 2.130$, $p = .033$) via personal importance.

Discussion

The primary hypothesis of this study was supported. We found that organizational involvement among the sample was low, de-

spite recent state legislative changes that increased the availability and funding for consumer involvement activities.

Additionally, our second hypothesis was generally supported. The sample reported wanting to be involved with several organizational involvement activities at higher rates than they were currently involved. Additionally, they reported believing this type of involvement was important for themselves and consumers as a whole.

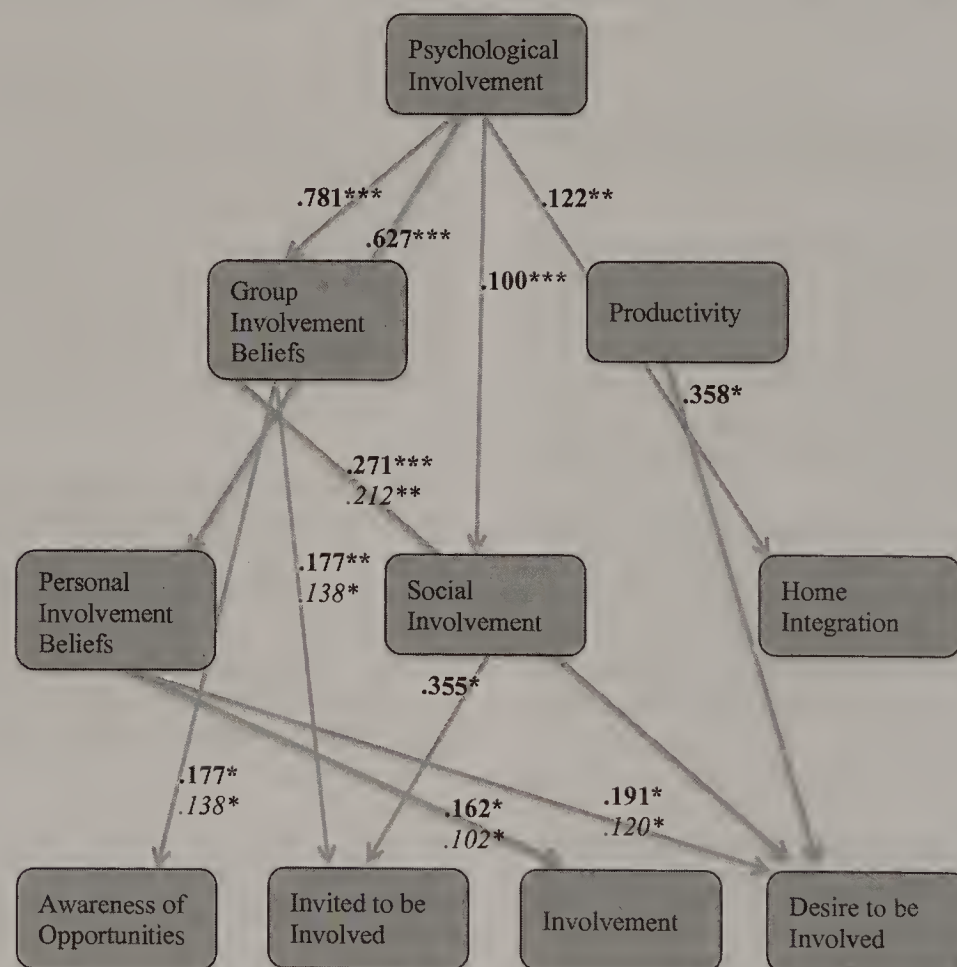


Figure 3. Diagram of path analysis modeling direct and indirect effects of consumer involvement domains and organizational involvement beliefs on levels of organizational involvement. Direct effects are bolded and indirect effects are italicized. * $p < .05$. ** $p < .01$. *** $p < .001$.

Lastly, our third hypothesis was not supported. Although one subdomain of physical involvement, *productivity*, did predict one subdomain of organizational involvement, desire to be involved, overall psychological involvement and beliefs about involvement were the greatest influences on levels of organizational involvement.

A major finding of this study is that there is a gap between preferred involvement and actual involvement. It is unclear whether the level of organizational involvement reported in this study is normative, because it is the first study of its kind that we are aware of in the United States. Future studies in this area will be able to collate data on this so that we can understand typical levels of organizational involvement and monitor changes as related legislation progresses. However, these results are unsurprising given documented difficulties implementing consumer involvement legislation internationally (Gordon, 2005; Kano et al., 2009). Understanding why organizational involvement is low, despite legislative initiatives and consumer desire for involvement, is central to closing this gap.

The findings of the path model and analyses conducted in this study, as well as previous findings, may hold some of the answers. Opposed to our hypothesis, we found that levels of organizational involvement were impacted most predominantly by organizational involvement beliefs, and indirectly by psychological involvement via organizational involvement beliefs. We may have been incorrect in our hypothesis, and higher order factors like psychological involvement more significantly impact organizational involvement. It is also possible that the CIQ does not measure key areas of physical involvement in for SMI populations, or that the variability in our sample was not large enough to detect effects. However, given the respectable effect sizes found in our model, the latter possibility appears unlikely.

This suggests that at present, feelings of community and belonging, and a desire to contribute to that community, are the most salient predictors of organizational involvement. It is unsurprising, then, that organizational involvement has remained low despite opportunities to become involved being set in place by the state. If psychological involvement is a critical factor to organizational involvement, then the number of significant barriers to psychological involvement in mental health service and policy sectors is likely to inhibit the impact of tangible legislative changes.

Tokenism, lack of respect for consumer involvement, and stigma have been identified as major barriers to consumer involvement (Gordon, 2005; Happell, 2010; Jacobson & Curtis, 2000; Lammers & Happell, 2003; Linhorst, Eckert, & Hamilton, 2005; Middleton et al., 2004; Tobin et al., 2002). In practice, these are overlapping mechanisms that prevent authentic opportunities for involvement. When consumer positions are created solely to adhere to a regulation, (e.g., Middleton et al., 2004) it is unlikely this position will contribute meaningfully. When consumers feel like they cannot speak up in their positions for fear of retribution (e.g., Linhorst et al., 2005), or that when they do, their opinions are dismissed (e.g., Lammers & Happell, 2003), it is likely they will contribute less and less. When administrators and providers are cynical of consumer intent (Happell, 2010), and seek to include only the "right" sorts of consumers, it is likely that representation will not be achieved and the status quo will continue.

In all of these cases there is an error in the implementation of consumer involvement. The foundation has not been laid. Con-

sumer involvement cannot be created in a vacuum; it is not merely a position or an activity but an approach. One of the major reasons for the success noted in Happell and Roper's (2009) case study on creating a consumer academic position is the fundamentally consumer-oriented approach the team took in creating and tailoring the position. This created a position that attended to consumer preferences and was supported and integrated with the rest of the staff, and yet provided autonomy to the position, preventing tokenism.

In many cases (e.g., Middleton et al., 2004), positions and activities are created without attention to the rest of the agency. They do not attempt to fill a needed service gap or integrate with other staff. They do not grant the consumers involved significant influence. There is no reason to believe that consumers would feel like they belong in such an environment—it has not yet been made welcoming to them. Our findings suggest, intuitively, that greater community change is needed to successfully implement consumer involvement.

We cannot ignore the possible impact of concrete barriers. There was an indication of these kinds of barriers by the significant variability in organizational involvement across activities. For two of the activities, consumers reported wanting to be involved with the activity at higher rates than they reported being aware of the activity. Additionally, in some cases consumers reported being invited to become involved at higher rates than they reported being involved. For instance, although consumers were invited to become involved in developing services at higher rates than they reported currently being involved, a significant number of consumers who had not been invited reported wanting to be involved.

These findings suggest that a primary barrier to organizational involvement may be simply knowing that activities exist and how to access specific activities of interest. Accessibility may hinder involvement among those who are interested in becoming involved, and consumers who value specific consumer involvement activities may not be the consumers targeted to become involved in those activities for a variety of reasons. Although it is unknown what the cause of these gaps are in our study, past literature has also found that lack of knowledge about consumer involvement activities (Tobin et al., 2002), accessibility, and inclusive consumer targeting (Happell, 2010) inhibits involvement.

Overall, this study indicates that although some progress has been made toward implementing needed consumer involvement initiatives in the United States, there are still considerable barriers. Fortunately, there is potential to increase organizational involvement by increasing psychological involvement and beliefs about organizational involvement. Ultimately, these two latter constructs are likely to be two sides of the same coin as indicated by our path analysis. As consumers' feelings of belonging to and acceptance by the community increases, their feelings of wanting to contribute to that community will also increase. Creating the kinds of communities that encourage psychological involvement by deliberate action, increased autonomy, and use of antistigma and prorecovery movement psychoeducation is important on its own. It will also promote organizational involvement by increasing beliefs about the importance of contributing to those communities and empowering consumers to believe that their contributions are possible and beneficial. Organizational involvement initiatives must walk the consumer involvement talk, though, and create communities that

truly are inclusive to consumers and positions that enable meaningful contribution by consumers.

Limitations

This study considered aspects of consumer involvement from a perspective not yet considered in the literature. While we believe that this has yielded interesting and important results, it also necessitated the use of imperfect methodology. We used a newly created survey to measure organizational involvement because there was no scale for this aspect of involvement, and we wanted to tailor the activities to our sample as much as possible. However, this limits the replicability of our study. Additionally, as there are no known parameters to compare our finding by, it is unclear how typical these findings are. This study can at minimum set parameters for SMI populations for future research to compare to.

A minority of participants reported confusion and unfamiliarity about some of the terms we used for our activities. As we were measuring familiarity with these activities, we believe that the results are still valid, although an activity like "program evaluation" may be called different things across programs.

Additionally, we focused specifically on one population, which limits the generalizability of our study. There was low variability in some measures, particularly levels of involvement and the productivity subdomain of physical involvement. We believe that this is characteristic of this population at this time, but also limits the ability to model impacts in a wider range of involvement. We did not use objective or secondary information to confirm consumers' reports of involvement. We did not take into account the impact of factors such as symptom severity, functionality, or court or other legal involvement on the ability to be involved.

In future studies, a wider array of involvement measures would be useful to understand the impact of involvement across areas of involvement. Measures could include both locally tailored as well as generally applicable items. An interview may be a better fit for a population such as this, which includes a large percentage of illiterate or minimally literate participants.

Conclusions

Although initiatives to increase consumer involvement were implemented, thus far the implementation has been unsuccessful. Levels of involvement in organizational involvement activities associated with these initiatives are low despite the value consumers place upon them. We argue that it is not enough to merely create organizational involvement opportunities; the structure of the system must change in congruence. By simultaneously tackling the two types of barriers identified in this article, namely, inadequate approach to implementation and concrete barriers, we believe that implementation of consumer involvement can improve. Ultimately, implementation must be meaningful, holistic, and accessible.

Keywords: consumer involvement; organizational involvement; mental health policy; serious mental illness; recovery movement

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Acculturative Heterogeneity Among Asian/Pacific Islanders in the United States: Associations With DSM Mental and Substance Use Disorders

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Extant studies on the links between acculturation and mental and substance use disorders among Asian/Pacific Islanders have been based on the assumption that acculturation is a homogeneous construct. However, emerging evidence suggests that the various components of acculturation do not manifest independently, but rather cluster in ways that reflect distinct profiles. We employ data on Asian/Pacific Islanders from the National Epidemiologic Survey on Alcohol and Related Conditions ($n = 968$). Latent profile analysis is used to identify acculturation subgroups on the basis of indicator variables related to cultural identification, language ability and preference, and social engagement. Subsequently, the distribution of outcome variables in the domains of DSM disorders (lifetime history of clinical, personality, and substance use disorders) is examined across latent subgroups. We identified a 5-class solution: Class 1: Separated (12.91%), Class 2: Partial Bilingual/Bicultural (30.06%), Class 3: English Dominant/Asian Oriented (12.29%), Class 4: Full Bilingual/Bicultural (19.42%) and Class 5: Assimilated (25.31%). The highest rates of clinical disorders were observed among members of the 2 classes characterized by a strong preference for the use of the English language (Classes 3 and 5). The highest prevalence of nicotine (12%) and illicit drug use (15%) disorders was observed among members of the Assimilated class. Consistent with prior research, findings suggest that risk of morbidity is greater among more acculturated individuals; however, findings also suggest that an important level of nuance can be observed with respect to acculturative subtypes identified on the basis of cultural identification, language ability and preference, and social engagement.

Asian/Pacific Islanders are the fastest growing racial/ethnic group in the United States (U.S.). Indeed, according to the U.S. Census Bureau (2010), the number of Asian/Pacific Islanders grew by 40% from 2000 to 2010, increasing at a rate 4 times faster than that of the total U.S. population. However, despite this rapid rate of growth, relatively little is known about the

health and well-being of Asian/Pacific Islanders, particularly with respect to the risk and protective factors associated with mental and substance use disorders (Sorkin, Nguyen, & Ngo-Metzger, 2011).

Although limited, accrued research suggests that the prevalence of mental and substance use disorders among Asian/Pacific Islanders may be higher than previously believed. For instance, while estimates of the lifetime prevalence of mood (9.1–12.8%), anxiety (9.8–10.9%), and substance use (4.0–11.9%) disorders among Asian Americans in general tend to be relatively low compared to other racial/ethnic subgroups (Breslau & Chang, 2006; Takeuchi et al., 2007), evidence suggests that the prevalence of psychiatric morbidity may vary substantially among Asian Americans across sociodemographic differences such as income and immigrant generation (Chung et al., 2003; Kalibatseva & Leong, 2011; Salas-Wright, Kagotho, & Vaughn, 2014; Salas-Wright & Vaughn, 2014). Moreover, it has been estimated that Asian/Pacific Islanders with mental disorders utilize psychiatric services at rates far below the national average (Wang et al., 2005). With respect to substance

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use disorders, the prevalence among Asian/Pacific Islanders in general tends to be lower than that of the national average; however, substantial variation exists within Asian/Pacific Islander subgroups (Price, Risk, Wong, & Klinge, 2002). For instance, Korean adults have been found to report levels of binge alcohol use that exceed that of the general population (SAMHSA, 2010). Similarly, rates of illicit drug use have been found to be markedly elevated among Hawaiians and other Pacific Islanders compared to other subgroups (Cochran, Mays, Alegria, Ortega, & Takeuchi, 2007). Because of the lack of a comprehensive study examining the prevalence of mental illness and substance use among Asian/Pacific Islanders, reported rates may be underestimated (Kohn, Saxena, Levav, & Saraceno, 2004).

Acculturation and Mental and Substance Use Disorders

A robust body of literature points to a relationship between acculturation and mental disorders among ethnic minority groups in the United States (Koneru, Weisman de Mamani, Flynn, & Betancourt, 2007). Studies suggest that risk for psychiatric morbidity is significantly greater among more acculturated individuals (Salas-Wright, Clark, Vaughn, & Córdova, 2014; Schwartz, Unger, Zamboanga, & Szapocznik, 2010). Recent evidence indicates that this pattern can be observed for a variety of mental and substance use disorders among Asian/Pacific Islanders in the United States (Burnett-Zeigler, Bohnert, & Ilgen, 2013). It should be noted, however, that most studies on acculturation and health are cross-sectional in nature and, consequently, are limited in terms of their capacity to disentangle the causal relationship between acculturation and health outcomes. Nevertheless, the current evidence suggests that individuals at higher levels of acculturation into mainstream American culture may be at increased risk for mental health and substance use morbidity.

The vast majority of studies on acculturation have conceptualized the process of cultural and psychological change either as a unidimensional or bidimensional construct; however, emerging evidence suggests this approach may be less than optimal. Recent studies suggest that acculturation is comprised of various conceptually distinct subcomponents that range from cultural practices to ethnic identity (Schwartz et al., 2014). Indeed, a process of “rethinking” the concept of acculturation is currently underway as leading researchers have proposed a multidimensional model of acculturation that takes into account the practices, values, and cultural identifications made by individuals in the process of transitioning from heritage to receiving cultures (Schwartz et al., 2010). In such an approach, constructs such as ethnic identity are conceptualized not as distinct from acculturation, but rather as essential subcomponents of this broader construct.

While much information can be gleaned from examining the links between the particular subcomponents of acculturation and mental disorders, it has become increasingly understood that the various components of acculturation do not manifest independently, but rather cluster together in ways that reflect distinct acculturative profiles. For instance, drawing from the basic conceptual framework of Berry’s (1980, 1997) seminal typology, Schwartz and Zamboanga (2008) identified numerous subgroups among a sample of Hispanic college students, including the “Assimilated” and the “Separated” as well as various bicultural sub-

groups (i.e., “Partial Bicultural,” “American-Oriented Bicultural,” “Full Bicultural”). Salas-Wright and colleagues (2014) conducted a similar analysis with a nationally representative sample of Hispanic adults in the United States and examined the links between latent subgroups and substance use disorders. Findings from this study suggest that, compared to monolingual/bicultural and assimilated English speakers, immigrants who are both bilingual and bicultural are substantially less likely to meet criteria for substance use disorders.

Gaps in the Literature

Although advances have been made in terms of our understanding of the relationship between acculturation and mental disorders among Asian/Pacific Islanders, important shortcomings persist. Most notably, extant studies that have examined the links between acculturation and mental disorders have done so under the assumption that acculturation is a homogeneous construct. That is, we are unaware of any previous studies that have modeled the heterogeneity of the various subcomponents of acculturation and, in turn, examined the relationship between particular acculturative subtypes and clinical, personality, and substance use disorders among Asian/Pacific Islanders in the United States. Additionally, relatively few studies have systematically examined the relationship between acculturation and mental disorders while drawing from nationally representative samples of Asian/Pacific Islanders. Specifying the heterogeneity is important to more accurately assess relations between acculturation components vis-à-vis mental health and substance use disorders.

The Present Study

We address the aforementioned shortcomings by drawing from a population-based longitudinal study (i.e., the National Epidemiologic Survey of Alcohol and Related Conditions [NESARC]). The NESARC is an advantageous data source given its far-reaching scope and generalizability; inclusion of a large sample of Asian/Pacific Islander adults; diagnostic assessment of clinical, personality, and substance use disorders; and inclusion of salient variables of relevance to acculturation. Specifically, we utilize a finite mixture modeling approach to model the heterogeneity of acculturation among Asian/Pacific Islander adults in the United States. Additionally, we examine the relationship between membership in acculturative subgroups and the prevalence of mental and substance use disorders. This two-step procedure allows us to advance the current understanding of the relationship between acculturation and mental and substance use disorders among a large and rapidly growing minority population in the United States.

Method

Sample and Procedures

Study findings are based on data ($n = 34,653$) from Wave II (2004–2005) of the NESARC. Using a multistage cluster sampling design, the NESARC is a nationally representative sample of noninstitutionalized U.S. residents aged 18 years and older (Grant et al., 2003; Grant & Dawson, 2006). The NESARC utilized a

multistage cluster sampling design, oversampling young adults and racial/ethnic minorities in the interest of obtaining reliable statistical estimation in these subpopulations, and to ensure appropriate representation of racial/ethnic subgroups. The survey gathered background data and extensive information about mental and behavioral health from individuals living in households and group settings (e.g., shelters, college dormitories, and group homes) in all 50 states and the District of Columbia. The current study restricted analyses to Asian/Pacific Islander adults ($n = 968$) ages 18 years or older, including respondents who reported that their ethnic/national heritage was Chinese (23%), Filipino (16%), Indian/Afghan/Pakistani (17%), Japanese (8%), Korean (7%), Vietnamese (8%), and from other Asian and Pacific Islander ethnic/national groups (21%).

Multistage cluster sampling design is a commonly used design when attempting to provide nationally representative estimates. This is because interviewing all participants is not feasible, so larger units (i.e., clusters) are identified and randomly selected from. With respect to the NESARC, 709 primary sampling units (PSUs) provided by the Census Supplementary Survey were selected (Stage 1). Within the sample PSUs, households were systematically selected (Stage 2). An individual age 18 or older was randomly selected from each household. The response rate for Wave I data was 81% and for Wave II was 86.7% ($N = 34,653$) with a cumulative response rate of 70.0% for both waves. Data were weighted at the individual and household levels to adjust for oversampling and nonresponse on demographic variables (i.e., age, race/ethnicity, sex, region, and place of residence). Data were also adjusted to be representative (based on region, age, race, and ethnicity) of the U.S. adult population as assessed during the 2000 Census. Study participants provided fully informed consent. The U.S. Census Bureau and the U.S. Office of Management and Budget approved the research protocol and informed consent procedures.

Diagnostic Assessment

Data were collected through face-to-face structured psychiatric interviews conducted by U.S. Census workers trained by the National Institute on Alcohol Abuse and Alcoholism and the U.S. Census Bureau. Interviewers administered the Alcohol Use Disorder and Associated Disabilities Interview Schedule–*DSM-IV* version (AUDADIS-IV), which has been shown to have good-to-excellent reliability in the diagnosis of mental disorders in the general population (Grant, Harford, Dawson, Chou, & Pickering, 1995; Hasin, Carpenter, McCloud, Smith, & Grant, 1997). Participants had the option of completing the NESARC interview in English, Spanish, or one of four Asian languages (Mandarin, Cantonese, Korean, and Vietnamese). The sample and procedures are described here in a summarized form; however, a more detailed description of the NESARC procedures is available elsewhere (Grant et al., 2003; Grant & Dawson, 2006).

Measures

Acculturation. Consistent with prior research (Salas-Wright et al., 2014) and theory (Schwartz et al., 2010), items

measuring the overlapping but distinct constructs of acculturation and ethnic identity were used as indicator variables in the latent modeling. Specifically, 12 items representing cultural identification, language ability and preference, and social engagement were utilized from the language orientation and ethnic social relations subscales from the Short Acculturation Scale (Marin, Sabogal, Marin, Otero-Sabogal, & Perez-Stable, 1987) as well as items the Ethnic Identity Scale (Guarnaccia et al., 2007). Cultural identification represents the degree to which respondents identified with their Asian/Pacific Islander orientation, and includes items on heritage, interpersonal comfort, identity, and shared values. Sample questions are: “Your race/ethnic heritage is important in your life” and “You identify with other people from your race/ethnic group.” Likert scale response options for these questions ranged from (1) *strongly agree* to (6) *strongly disagree*. With respect to language ability and preference, items examined the linguistic capacity and preference of participants in general and in various social situations, including the language they typically read/speak, languages spoken at home, the language of thought, and the language used with friends. Sample items include: “In general, what languages do you read and speak?” and “Which languages do you usually speak with your friends?” Likert scale response options ranged from (1) *only Asian/Pacific Islander language* to (5) *only English*. Measures of social engagement included preferences relating to visitors, friendships, social gatherings, and close friends. The prompts for the measures of social engagement include: “The persons you visit, or who visit you” and “Please tell me who your close friends are.” Response options for these measures ranged from (1) *all from my race/ethnic group* to (5) *all from other racial/ethnic groups*.

DSM disorders. Lifetime history of clinical (e.g., major depressive disorder, generalized anxiety disorder) and personality disorders (e.g., antisocial personality disorder and schizotypal personality disorder) was assessed. Additionally, three substance use disorders were examined: nicotine dependence and lifetime alcohol or any illicit drug (e.g., cannabis, opiates) use disorder (abuse/dependence). Although the use of past 12 months of measures for substance use disorders would be optimal, we relied on lifetime measures because of problems with cell size and model stability. Consistent with the original NESARC coding, each item was dichotomously scored (0 = *no*, 1 = *yes*).

Sociodemographic variables. The following sociodemographic variables were also examined and included as indicator covariates in the latent modeling: age, gender, household income, education level, and immigrant status. It should be noted that both “native-born” and “second-generation” respondents were born in the United States and therefore these terms are slightly imprecise. Nevertheless, we elected to use these terms as they are consistent with the work of scholars in prior research on immigration and health (e.g., Escobar, Nervi, & Gara, 2000; Glaesmer et al., 2011; Salas-Wright, Vaughn, Clark, Terzis, & Córdova, 2014).

Statistical Analyses

This study utilized latent profile analysis (LPA) to identify latent acculturation subgroups on the basis of 12 indicator variables related to cultural identification, language ability and pref-

erence, and social engagement. Sociodemographic indicator covariates were also included in the modeling of the latent subgroups. Subsequently, the distribution of outcome variables in the domains of mental and substance use disorders was examined in relation to the latent subgroups identified in the LPA analysis.

Beginning with the LPA, a sequence of latent class models was identified between one and six classes using Latent GOLD[®] 4.5 (Vermunt & Magidson, 2008) software. Five statistical criteria were used to identify the best fitting model: the Bayesian information criterion (BIC), Akaike's information criterion (AIC), consistent Akaike's information criterion (CAIC), log likelihood, and entropy. In interpreting these criteria, lower BIC, AIC, and CAIC values and higher log likelihood and entropy values reflect better model fit. In addition to these quantitative criteria, the parsimony and substantive interpretability of the latent class solutions also function as key criteria for the selection of the final model. After identifying latent subgroups and assigning subjects to classes on the basis of the probability of membership, the distributions of outcome variables were examined by means of contingency tables and chi-square tests. Consistent with previous studies of Asian/Pacific Islanders using the NESARC data (Breslau & Chang, 2006), we exclusively examined respondents from this subgroup and made use of Taylor series linearization using Stata 13.1 SE software (StataCorp, 2013) to adjust for standard errors of estimates for complex survey sampling design effects. Additional information about the sampling weights used in the NESARC is described in greater detail elsewhere (Grant, Kaplan, Shepard, & Moore, 2003).

Results

Modeling of Latent Subgroups

As seen in Table 1, the statistical criteria suggest that a five-class solution was the optimal modeling of the data. Whereas the values for the fit indices suggest that the addition of a sixth class would slightly improve model fit, these differences are relatively minor. Moreover, the accelerated flattening of the differences in the log likelihood, BIC, AIC and CAIC values between the five- and six-class solutions suggests that the addition of a sixth class would not be parsimonious. Additionally, the conceptual fit of the latent class models was examined by plotting the mean values of the 12 indicator variables across each of the latent classes. As illustrated in Figure 1, the five-class solution provides a clearly distinguishable and conceptually coherent modeling of the heterogeneity of the data.

The five-class solution is comprised of Class 1: Separated ($n = 125$; 12.91%), Class 2: Partial Bilingual/Bicultural ($n = 291$; 30.06%), Class 3: English Dominant/Asian Oriented ($n = 119$; 12.29%), Class 4: Full Bilingual/Bicultural ($n = 188$; 19.42%), and Class 5: Assimilated ($n = 245$; 25.31%). Class 1 (Separated) is characterized by universally low levels of acculturation across the domains of cultural identification, language ability and preference, and social engagement. Class 2 (Partial Bilingual/Bicultural) is characterized by a pattern of more moderate scores with respect to the aforementioned domains. For instance, the mean score for languages read/spoken and preference for social gatherings were 2.75 (3 = read/speak non-English and English language "both equally") and 2.63 (3 = "about half and half" from my racial/ethnic group and other groups), respectively. Class 3 (English Dominant/Asian Oriented), the most variable of all classes in terms of the mean values of the indicator variables, is characterized by strong identification with Asian/Pacific Islander culture and a clear preference for social engagement with Asian/Pacific Islanders in combination with a clear tendency to speak English more than non-English languages. Class 4 (Full Bilingual/Bicultural) represents an incremental increase in acculturation from Class 2 in terms of the mean values for cultural identification, language ability and preference, and social engagement. Class 5 (Assimilated) is characterized, with the exception of heritage, by universally elevated levels of acculturation across all three domains.

Sociodemographic Characteristics of Latent Subgroups

Table 2 displays the bivariate associations between membership in the five latent acculturation subgroups and sociodemographic factors. Significant differences were observed for age ($F = 19.66$, $p < .001$) with the highest mean value for age identified among members of Class 1 ($M = 54.77$, $SD = 16.35$) and a more circumscribed range observed among the remaining classes. In terms of gender, significant differences were also observed ($\chi^2 = 14.02$, $p < .001$). Class 1 (Separated) had the lowest proportion of male respondents (35.04%) and Class 2 (Partial Bilingual/Bicultural) had the highest proportion of male respondents (54.01%). Significant differences were also observed with respect to household income ($\chi^2 = 98.31$, $p < .001$). Class 4 (Full Bilingual/Bicultural) had the highest proportion of respondents residing in households earning more than \$70,000 per year (46.09%) which was substantially greater than Class 1 (Separated), which had the lowest percentage of respondents residing in households earning more than \$70,000

Table 1. *Fit Indices for Latent Classes*

Class solution	Log likelihood	BIC	AIC	CAIC	Entropy
1 Class	-17589.04	35542.46	35284.08	35595.46	n/a
2 Classes	-15412.19	31381.28	30986.39	31462.28	0.9178
3 Classes	-14650.45	30050.27	29518.87	30159.27	0.9152
4 Classes	-14348.15	29638.18	28970.27	29775.18	0.9106
5 Classes	-14038.59	29211.59	28407.18	29376.59	0.9068
6 Classes	-13888.60	29104.13	28163.21	29297.13	0.9062

Note. AIC = Akaike's information criterion; BIC = Bayesian information criterion; CAIC = consistent Akaike's information criterion.

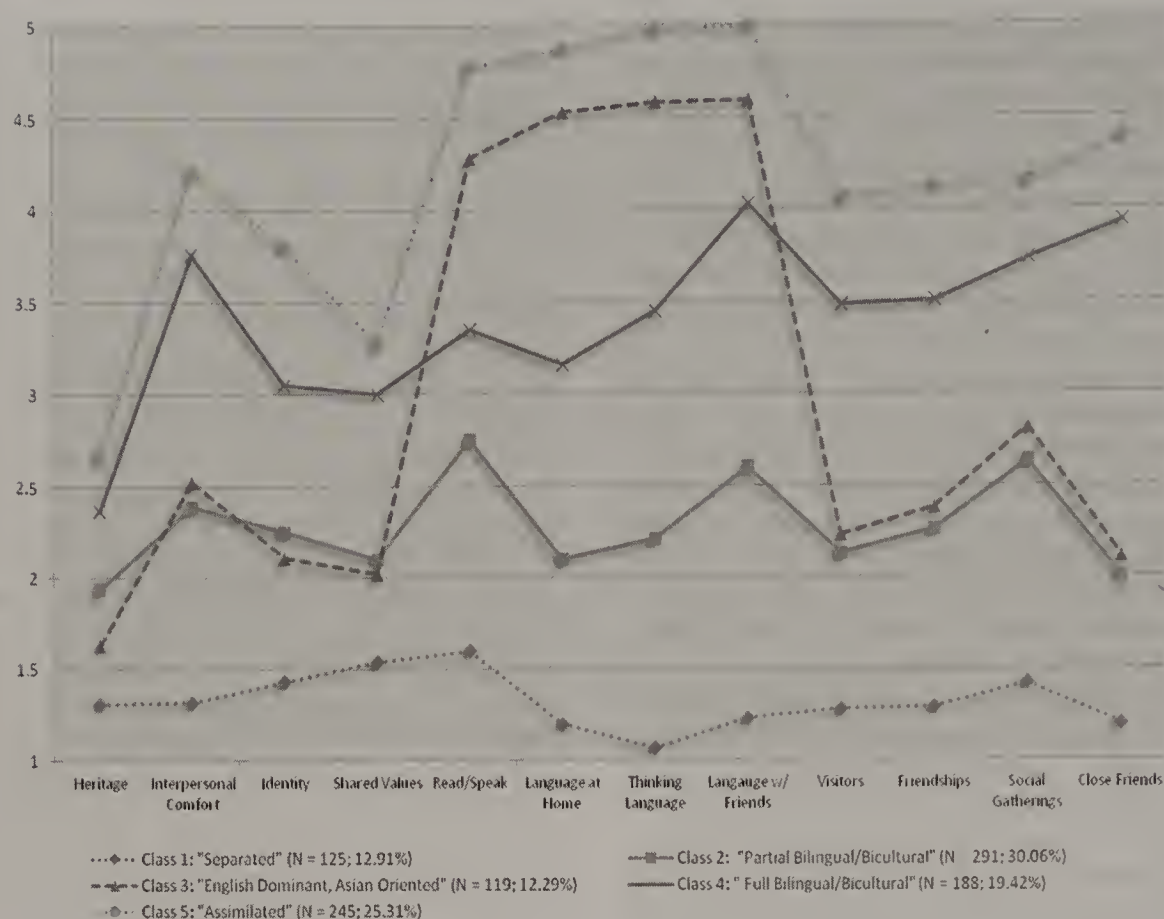


Figure 1. Characteristics of latent classes. See the online article for the color version of this figure.

per year (13.92%). A similar pattern of differences was observed with regard to education level as the highest proportion of respondents with some college education or more was observed among Class 4 (Full Bilingual/Bicultural; 88.01%) and the lowest proportion was observed among Class 1 (Separated; 30.23%; $\chi^2 = 198.13$, $p < .001$). Finally, with regard to immigrant status, a clear and significant pattern of differences was observed ($\chi^2 = 384.42$, $p < .001$). Among Class 1 (Separated; 99.51%) and Class 2 (Partial Bilingual/Bicultural; 95.43%) the proportion of first-generation immigrants was markedly elevated, as was the proportion among Class 4 (Full Bilingual/Bicultural; 88.84%). Far more variability was observed among members of Class 3 (English Dominant/Asian Oriented) and Class 5 (Assimilated), which were comprised of 34.10% and 40.12% first-generation immigrants, respectively.

We also examined the characteristics of the latent classes with respect to age at the time of migration, duration in the United States, and ethnic/national heritage. Notably, not all study participants were included in the analyses of age at the time of migration and duration in the United States as roughly one in four (24.1%) Asian/Pacific Islanders in the sample were nonimmigrants. Significant bivariate differences were observed with respect to the age upon arrival to the United States ($F = 74.93$, $p < .001$) and duration in the United States ($F = 17.25$, $p < .001$). By far, the age ($M = 37.0$, $SD = 13.8$) at the time of arrival was highest among members of Class 1 (Separated) followed by members of Class 2 (Partial Bilingual/Bicultural) with a mean age of 27.0 years ($SD = 9.9$). Members of Class 1 and 2 also reported the shortest duration in the United States

with a mean duration of 17.9 ($SD = 11.4$) and 17.2 years ($SD = 11.2$), respectively. Post hoc analyses revealed that the mean values for age upon arrival among members of Classes 3 (English Dominant, Asian Oriented; $M = 21.5$, $SD = 13.8$) and 4 ($M =$ Full Bilingual/Bicultural; 22.6, $SD = 11.1$) were not significantly different from one another. Similarly, no significant differences were observed between members of Class 3 ($M = 21.3$, $SD = 11.4$) and Class 4 ($M = 20.1$, $SD = 11.6$) with respect to duration in the United States. Immigrant members of Class 5 (Assimilated) were far and away the youngest upon arrival to the United States ($M = 11.8$, $SD = 9.5$). Members of Class 5 also reported the longest duration in United States of any group ($M = 28.1$, $SD = 11.5$).

Table 3 displays the proportion of individuals in each of the ethnic/national heritage groups for each of the five latent classes. Class 1 (Separated) had the highest proportion of Chinese (35.74%) and Vietnamese (15.55%) respondents and the smallest proportion of Filipino (4.22%) and Japanese (1.39%) respondents of all of the latent classes. Class 3 (English Dominant, Asian Oriented) had the largest proportion of respondents classified as "other" (30.79%) and the smallest proportion of Korean (2.60%) and Vietnamese (2.58%) respondents. Class 4 (Full Bilingual/Bicultural) stood out as having the large proportion of Indian/Afghan/Pakistani respondents (25.46%) and the smallest proportion of respondents classified as "other" (12.47%). Finally, Class 5 (Assimilated) had the smallest proportion of Chinese (18.38%) and Indian/Afghan/Pakistani (9.16%) respondents and the largest proportion of Japanese respondents (18.63%).

Table 2. Sociodemographic Characteristics by Latent Class

	Class 1: Separated (<i>n</i> = 125; 12.91%) <i>M</i> (<i>SD</i>)/%	Class 2: Partial Bilingual/Bicultural (<i>n</i> = 384; 15.37%) <i>M</i> (<i>SD</i>)/%	Class 3: English Dominant, Asian Oriented (<i>n</i> = 119; 12.29%) <i>M</i> (<i>SD</i>)/%	Class 4: Full Bilingual/Bicultural (<i>n</i> = 188; 19.42%) <i>M</i> (<i>SD</i>)/%	Class 5: Assimilated (<i>n</i> = 245; 25.31%) <i>M</i> (<i>SD</i>)/%	<i>F</i> / χ^2
Sociodemographic factors						
Age	54.77 (16.35)	44.10 (14.40)	44.29 (16.67)	42.16 (13.69)	40.76 (14.99)	19.66***
Gender						
Female	64.96	45.99	51.60	51.01	50.21	14.02***
Male	35.04	54.01	48.40	48.99	49.79	
Household income						
<\$20,000	33.44	12.60	18.52	9.65	13.68	98.31***
\$20,000–\$34,999	29.87	15.32	7.02	12.02	11.20	
\$35,000–69,999	22.76	37.92	32.17	32.24	31.83	
>\$70,000	13.92	34.16	42.30	46.09	43.29	
Education level						
Less than H.S.	41.71	9.44	6.16	2.53	5.52	198.13***
H.S. graduate	28.07	16.91	21.36	9.45	12.35	
Some college ⁺	30.23	73.65	72.47	88.01	82.13	
Immigrant status						
First generation	99.51	95.43	34.10	88.84	40.12	384.42***
Second generation	0.49	4.03	37.31	9.05	38.54	
Nonimmigrant	0.00	0.53	28.59	2.13	21.34	

Note. *SD* = standard deviation; H.S. = high school. All percentages are reported as column percentages.

* $p < .05$. ** $p < .01$. *** $p < .001$.

Mental and Substance Use Disorders Among Latent Subgroups

Table 4 displays the bivariate associations between membership in the five latent subgroups and the prevalence of lifetime mental and substance use disorders. With respect to clinical disorders, significant differences were observed across the latent subgroups ($\chi^2 = 11.06$, $p < .001$). Class 3 (English Dominant/Asian Oriented) has the highest proportion of respondents who met criteria for a clinical disorder (30.75%) followed closely by Class 5 (Assimilated) with 27.62% of class members meeting criteria for a clinical disorder. The lowest prevalence of clinical disorders was observed among Class 2 (Partial Bilingual/Bicultural; 18.52%) followed by Class 1 (Separated; 19.70%) and Class 4 (Full Bilingual/Bicultural; 21.29%). In terms of personality disorders, the highest prevalence again was observed among Class 3 (English Dominant/Asian Oriented; 19.73%) followed closely by members

of Class 5 (Assimilated; 18.76%) and Class 4 (Full Bilingual/Bicultural; 17.94%). Substantially lower rates of personality disorders were observed among members of Class 1 (Separated; 6.69%) and Class 2 (Partial Bilingual/Bicultural; 11.27%).

With regard to DSM substance use disorders, significant differences were observed across subgroups for nicotine dependence ($\chi^2 = 14.30$, $p < .001$), as well as alcohol ($\chi^2 = 77.61$, $p < .001$) and illicit drug use disorders ($\chi^2 = 55.48$, $p < .001$). In terms of nicotine dependence, the highest prevalence was observed among members of Class 5 (Assimilated; 12.47%) and the lowest prevalence observed among Class 2 (Partial Bilingual/Bicultural; 3.91%) followed closely by Class 1 (Separated; 5.90%). As for alcohol and illicit drug use disorders, markedly lower rates of morbidity were observed among members of Class 1 (AUD = 1.19%, IDUD = 0.70%) and Class 2 (AUD = 8.27%, IDUD = 0.84%). The highest rates of alcohol use disorder were observed

Table 3. Ethnic/National Heritage Across Latent Classes

	Class 1: Separated	Class 2: Partial Bilingual/Bicultural	Class 3: English Dominant, Asian Oriented	Class 4: Full Bilingual/Bicultural	Class 5: Assimilated
Ethnic/National heritage	% [95% CI]	% [95% CI]	% [95% CI]	% [95% CI]	% [95% CI]
China	35.74 [33.3, 38.2]	23.01 [21.7, 24.4]	20.82 [18.9, 22.8]	19.88 [18.3, 21.5]	18.38 [17.4, 19.4]
Philippines	4.22 [3.9, 4.5]	19.20 [16.3, 22.5]	18.06 [15.6, 20.8]	15.56 [14.4, 16.8]	16.47 [14.8, 18.2]
India/Afghanistan/Pakistan	14.60 [9.7, 21.4]	20.13 [18.9, 21.3]	10.89 [10.4, 11.4]	25.46 [24.6, 26.3]	9.16 [8.7, 9.6]
Korea	9.6 [8.8, 10.5]	5.77 [5.4, 6.1]	2.60 [2.5, 2.7]	8.73 [8.5, 9.0]	6.15 [4.5, 8.3]
Vietnam	15.55 [14.5, 16.6]	7.66 [7.2, 8.1]	2.58 [2.5, 2.7]	10.30 [10.0, 10.6]	3.16 [2.6, 3.8]
Japan	1.39 [1.3, 1.5]	3.36 [3.2, 3.6]	14.26 [13.7, 14.8]	7.60 [7.4, 7.8]	18.63 [15.3, 22.4]
Other	18.88 [17.6, 20.2]	20.86 [17.5, 24.6]	30.79 [27.9, 33.9]	12.47 [10.5, 14.8]	28.05 [26.0, 30.1]

Note. CI = confidence interval. All percentages are reported as column percentages.

Table 4. *Mental and Substance Use Disorders Across Latent Classes*

	Class 1: Separated (<i>n</i> = 125; 12.91%)		Class 2: Partial Bilingual/Bicultural (<i>n</i> = 384; 15.37%)		Class 3: English Dominant, Asian Oriented (<i>n</i> = 119; 12.29%)		Class 4: Full Bilingual/Bicultural (<i>n</i> = 188; 19.42%)		Class 5: Assimilated (<i>n</i> = 245; 25.31%)		χ^2
	%	[95% CI]	%	[95% CI]	%	[95% CI]	%	[95% CI]	%	[95% CI]	
<i>DSM-IV</i> mental disorders											
Clinical	19.70	[17.5, 22.1]	18.52	[16.3, 20.9]	30.75	[28.9, 32.6]	21.29	[20.6, 21.9]	27.62	[26.1, 29.2]	11.06***
Personality	6.69	[6.2, 7.2]	11.27	[10.6, 11.9]	19.73	[16.3, 23.6]	17.94	[15.9, 20.1]	18.76	[17.0, 20.6]	16.77***
<i>DSM-IV</i> substance use disorders											
Nicotine	5.90	[5.5, 6.3]	3.91	[3.7, 4.1]	7.07	[5.3, 9.3]	7.63	[7.4, 7.9]	12.47	[11.5, 13.5]	14.30***
Alcohol	1.19	[1.1, 1.3]	8.27	[7.8, 8.8]	26.74	[23.1, 30.6]	10.88	[10.3, 11.5]	28.11	[26.8, 29.4]	77.61***
Illicit drugs	0.70	[0.65, 0.75]	0.84	[0.80, 0.89]	6.09	[0.58, 0.63]	8.49	[8.2, 8.7]	15.30	[14.1, 16.6]	55.48***

Note. *DSM-VI* = *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition; CI = confidence interval. All percentages are reported as column percentages.

* $p < .05$. ** $p < .01$. *** $p < .001$.

among Class 5 (Assimilated; 28.11%) followed closely by Class 3 (English Dominant/Asian Oriented; 26.74%). With respect to illicit drug use disorder, the highest prevalence was again observed among Class 5 (Assimilated; 15.30); however, the second highest rates were observed among members of Class 4 (Full Bilingual/Bicultural; 8.49%). Finally, in terms of comorbid mental and substance use disorders, the highest prevalence was observed among members of Class 5 (Assimilated; 18.83%) followed by Class 3 (English Dominant/Asian Oriented; 15.98%).

Discussion

The relationship between increased acculturation and greater risk for mental and substance use disorders has been well established among major immigrant populations in the United States (Burnett-Zeigler et al., 2013; Koneru et al., 2007). Notably, however, most of this research has examined this link using either composite measures of acculturation or instruments designed to independently measure various subcomponents of acculturation. This is noteworthy in light of an emerging body of evidence that suggests that the various subcomponents of acculturation—such as cultural identification, language ability and preference, and social engagement—tend to be incorporated in the lives of individuals in ways that reflect relatively distinct and stable profiles (Schwartz et al., 2010; Schwartz & Zamboanga, 2008), and confer risk with regard to psychiatric morbidity (Salas-Wright et al., 2014). Cognizant of such shortcomings, we utilized a population-based study with a large population of Asian/Pacific Islanders in the United States in the exploration of two interrelated questions. First, can we model the acculturative heterogeneity of Asian/Pacific Islanders in the United States such that substantively meaningful subgroups can be identified? Second, if so, can we identify differences with regard to mental and substance use disorders across the acculturative subgroups? Our exploration of these questions provides new evidence on the relationship between acculturation and mental disorders among Asian/Pacific Islanders in the United States.

Study results revealed five substantively meaningful acculturative subgroups among Asian/Pacific Islanders in the United States. First, roughly one in four (25%) Asian/Pacific Islanders were

classified as Assimilated to the culture of the United States. Members of this class were found to report moderate-to-high levels of Asian/Pacific Islander identity, in combination with elevated levels of linguistic and social acculturation. Additionally, just under half of respondents were categorized into either the partial (30%) or full (19%) bilingual/bicultural classes which were characterized by moderate levels of Asian/Pacific Islander identity in combination with acculturative flexibility with respect to linguistic and social engagement. Approximately one in eight (12%) Asian/Pacific Islanders were classified as English Dominant, Asian Oriented. Members of this class reported a strong identification with their Asian/Pacific Islander heritage as well as a strong preference for social engagement with Asian/Pacific Islanders, but tended to either be monolingual English speakers or strongly prefer the use of the English language. Finally, roughly one in eight respondents (13%) were categorized into the Separated class, which was characterized by universally low levels of acculturation across cultural, linguistic, and social domains. Members of this class tended to be disproportionately first-generation female immigrants who were relatively older, less educated, and economically disadvantaged compared to members of the other classes. Notably, four of the five classes (Classes 1, 2, 4, and 5) identified represent something akin to an acculturative gradient ranging from low to high acculturation; however, the English Dominant, Asian Oriented class stands out as categorically distinct inasmuch as members of this group are characterized by high linguistic acculturation in combination with a strong sense of Asian identity and a preference for social engagement with individuals from their same racial/ethnic group.

Study findings also point to a number of noteworthy links between acculturative subtypes and the prevalence of mental disorders. With respect to clinical disorders, the highest rates of morbidity were observed among members of the two classes characterized by a strong preference for the use of the English language (i.e., the English Dominant, Asian Oriented [31%] and Assimilated [28%] classes). These rates were markedly higher than those observed among the three remaining classes, which were clustered closely together ranging from roughly 19% to 21%. This pattern of findings is consistent with prior research suggesting a potential link between linguistic acculturation and psychiatric mor-

bidity (Koneru et al., 2007). Similarly, the highest prevalence of personality disorders was observed among the two English-dominant classes (i.e., the English Dominant, Asian Oriented [20%] and Assimilated [19%] classes); however, the prevalence of personality disorders among the Full Bilingual/Bicultural (18%) class was closely aligned with these two classes. Much larger differences were observed among members of the Separated (7%) and Partial Bilingual/Bicultural (11%) classes. In terms of personality disorders, these findings seem to suggest that risk for personality disorders may be lower among Asian/Pacific Islanders who maintain a separated status from mainstream American culture.

With respect to the links between acculturative subtypes and substance use disorders, a somewhat distinct pattern of findings was observed. Far and away, the highest prevalence of nicotine (12%) and illicit drug use (15%) disorders was observed among members of the Assimilated class. This finding is certainly consistent with previous research highlighting a link between greater levels of acculturation and substance use disorders (Burnett-Zeigler et al., 2013; Koneru et al., 2007); however, it is noteworthy that substantially lower levels of morbidity were observed among members of the English Dominant, Asian Oriented class (nicotine = 7%, illicit drugs = 6%) as this is in contrast to the pattern observed with respect to mental disorders. A distinct pattern was observed with respect to alcohol use disorder. Namely, the highest rates were still observed among the Assimilated class (28%), but very similar rates were observed among the English Dominant/Asian Oriented (27%) class. These rates were substantially greater than those observed among the Separated (1%), Partial Bilingual/Bicultural (8%), and Full Bilingual/Bicultural (11%) classes. This pattern of findings is in accordance with previous research pointing to a link between the loss of one's language of origin and increased risk for substance use disorders (Park, Anastas, Shibusawa, & Nguyen, 2014; Salas-Wright et al., 2014; Unger et al., 2000).

Study Limitations

Study findings should be interpreted in light of several limitations. First, although the study examined acculturation with respect to cultural identification, language ability and preference, and social engagement, prior theorizing have pointed to the importance of considering additional factors of relevance to acculturation (Schwartz et al., 2010). For example, we do not have data on factors such as the consumption of traditional food or the celebration of traditional holidays. Second, because of low base rates, statistical analyses were limited to an examination of lifetime measures of mental and substance use disorders. It is possible that an examination of mental and substance use disorders over the course of a more circumscribed timeframe (e.g., last 12 months, last 30 days) might yield different results. Moreover, this approach does not allow us to discern whether or not substance use morbidity was in reference to a period of time before arrival to the United States which, consequently, limits our capacity to determine whether acculturation played a role in the etiology of disorders. Finally, the NESARC is not a true longitudinal investigation and, consequently, caution should be exercised in the interpretation of the temporal relationships between acculturation and mental and substance use disorders. Fundamentally, ours is a correlational study that examines the cross-sectional association between

variables measuring acculturation and substance use disorders. A life course study design with more circumscribed measures of substance use disorders would be necessary to truly measure the causal impact of acculturation in the etiology of substance use disorders.

Conclusions

Study findings suggest that an important degree of heterogeneity can be observed in terms of the cultural, linguistic, and social acculturation of Asian/Pacific Islanders in the United States. Although we do not formally compare latent class models with more traditional dimensional models of acculturation, study findings are consistent with much of the seminal research on the acculturative typologies (Berry, 1980, 1997) as well as an emerging body of literature that has focused on the distinct profiles of individuals from the nation's rapidly growing immigrant populations (Salas-Wright et al., 2014; Schwartz et al., 2010; Schwartz & Zamboanga, 2008). Consistent with prior research on the relationship between acculturation and mental and substance use disorders, findings suggest that risk of morbidity is greater among individuals at higher levels of acculturation; however, findings also suggest that an important level of nuance can be observed with respect to acculturative subtypes identified on the basis of cultural identification, language ability and preference, and social engagement. Clinical implications of the current study are that Asian/Pacific Islanders, particularly those who are either monolingual English speakers or prefer the use of English language, should be monitored for potential psychiatric morbidity and targeted in prevention programs designed to address mental health and substance use problems.

Keywords: acculturation; Asian Americans; mental disorders; substance use disorders

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Differential Accounts of Refugee and Resettlement Experiences in Youth With High and Low Levels of Posttraumatic Stress Disorder (PTSD) Symptomatology: A Mixed-Methods Investigation

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In recent years there has been increased debate and critique of the focus on psychopathology in general, and posttraumatic stress disorder (PTSD) in particular, as a predominant consequence of the refugee experience. This study was conducted to broaden the conceptualization and examination of the outcomes of the refugee experience by jointly examining how adaptive processes, psychosocial factors, and psychopathology are implicated. A mixed-methods approach was used to specifically examine whether adolescents' ($N = 10$) accounts of their refugee and resettlement experiences differed according to their level, "high" or "low," of PTSD symptomatology. The superordinate themes of cultural belongingness and identification, psychological functioning, family unit functioning and relationships, and friendships and interpersonal processes, were identified as having particular relevance for the study's participants and in distinguishing between participants with high and low levels of PTSD symptomatology. Findings were characterized by marked differences between adolescents' accounts according to their symptomatology levels, and may thereby inform important avenues for future research as well as clinical prevention and intervention programs with refugee youth.

The mental health impacts of the refugee experience have been widely studied, with research demonstrating that conditions including depression (Papageorgiou et al., 2000; Tousignant et al., 1999), anxiety (Papageorgiou et al., 2000), and posttraumatic stress disorder (PTSD; Drury & Williams, 2012; Fazel & Stein, 2002) are experienced by significant proportions of resettled refugees. PTSD is a commonly reported psychological condition experienced by people from refugee backgrounds (Drury & Williams, 2012; Fazel & Stein, 2002), and has been the subject of particular focus in the extant literature (Reed, Fazel, Jones, Panter-Brick, & Stein, 2012). Despite evidence for its validity in refugee populations (Hinton & Lewis-Fernandez, 2011; Sack, Seeley, & Clarke, 1997; van Rooyen & Nqweni, 2012), and consistent findings that a small but significant proportion of refugees expe-

rience the disorder (Fazel & Stein, 2002; Fazel, Wheeler, & Danesh, 2005), there remains ongoing controversy around the conceptualization and the examination of the condition (De Haene, Grietens, & Verschueren, 2007; Porter, 2007).

Though the dominant frameworks of enquiry in refugee studies have focused on examining psychopathology as the major outcome of the refugee experience, many unanswered questions regarding psychological disorders, PTSD in particular, in refugee populations prevail, including: why population prevalence rates of psychological conditions remain relatively low, despite the often considerable traumata refugees have endured (Drury & Williams, 2012; Fazel & Stein, 2002); whether the use of PTSD and other associated westernized paradigms of mental health are appropriate and cross-culturally applicable to ethnically diverse populations (Borwick, Schweitzer, Brough, Vromans, & Shakespeare-Finch, 2013; Bracken, Giller, & Summerfield, 1995; Hinton & Lewis-Fernandez, 2011); the mechanisms behind the lack of psychosocial functional impairment in those who do meet clinical criteria for PTSD and other disorders (Drury & Williams, 2012; Mels, Derluyn, Broekaert, & Rosseel, 2010); and whether the focus on psychopathology in general, and PTSD in particular, as a major outcome of the refugee experience fails to explicate broader psychosocial factors (such as language proficiency, employment, and social support that may interact with an individual's psychological functioning after trauma to influence the development of psychopathology) and adaptive processes that may be impacted by the

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refugee experience (Porter, 2007; Schweitzer, Melville, Steel, & Lacherez, 2006; Silove, 1999).

In partly addressing some of the aforementioned critiques, Silove (1999) proposed an alternative theoretical approach (the Adaptation and Development After Persecution and Trauma model; the ADAPT model) from which to view the impacts of the refugee experience, both at an individual and at a community level. Silove (1999, 2013) details five core “adaptive systems” (safety, attachment, justice, identity and role, and existential meaning systems) that may be fundamentally disrupted in both individuals and war-exposed communities that may explicate intervening processes that link psychopathological outcomes, such as PTSD, to traumatic events. Indeed, research demonstrates that adaptive processes, including coping strategies (Sachs, Rosenfeld, Lhewa, Rasmussen, & Keller, 2008; Seglem, Oppedal, & Roysamb, 2014), emotional and social support (Fazel, Reed, Panter-Brick, & Stein, 2012; Montgomery & Foldspang, 2008), positive familial relationships (Fazel et al., 2012; Rousseau, Drapeau, & Platt, 1999), and the maintenance of a sense of faith and ideological conviction (Borwick et al., 2013; Sachs et al., 2008), positively influence mental health in refugee populations. Importantly, the ADAPT model (Silove, 1999, 2013) provides a significant divergence from the psychopathological discourse that has dominated the refugee literature to date. In emphasizing that organized violence may impact societal and communal processes, the model seeks to shift the conceptualization of the refugee experience’s impact away from a purely individualized one to consider important relational and social sequelae also.

The present study draws influence from Silove’s (1999, 2013) ADAPT model, the broader findings regarding adaptive and psychosocial factors implicated in refugee populations, and the aforementioned critique of the extant literature. In extending from much of the previous research on the topic, we sought to obtain adolescents’ accounts of their refugee and resettlement experiences, in view of exploring possible psychosocial and adaptive mechanisms that may play a role in participants’ psychopathology, conceptualized for this study as PTSD symptoms. We specifically sought to explore whether such factors differentiated those adolescents who had few symptoms from those who had elevated levels of PTSD symptomatology. Importantly, we utilized a mixed-methods approach (Bergman, 2008), where qualitative interview data were used to illustrate and expand upon quantitative data on the level of psychopathology (conceptualized for this study as the level of PTSD symptoms) and also to give voice to adolescents themselves, something that has been notably lacking in the literature to date (Borwick et al., 2013).

Method

Participants

Participants who self-identified as being from a refugee background and were living in Hobart or Melbourne, Australia, participated in the study. Inclusion criteria for all participants comprised (a) between 12 and 21 years of age, (b) residing in Australia for 6 months or more, (c) sufficient English capabilities if they did not wish to use an interpreter, and (d) consented for their interview to be audio-recorded and transcribed. Data were collected from between April, 2012 and August, 2013. Participants for the present

study were selected from a larger participant pool who had all completed the semistructured interview and Child Posttraumatic Stress Scale (CPSS). Participants for the final sample were chosen based on whether they obtained particularly high or low CPSS scores (see results section for mean CPSS scores of each group), and the length and detail of their interview data. The final sample included 10 participants (eight females and two males), with five participants in each group. Participants were selected into the high and low groups if they had CPSS scores of 15 and above, or 10 and below, respectively. Further demographic information pertaining to the participants’ demographic information is shown in Table 1.

Measures

Semistructured interview. Participants took part in a semistructured interview, The Youth Experience Scale for Refugees (YES-R; McGregor, Melvin & Newman, 2014), developed for use in this study. The interview schedule was developed to assess the Adaptation and Development After Persecution and Trauma model (the ADAPT model; Silove, 1999, 2013), as well as the authors’ broader knowledge of issues experienced by youth from refugee backgrounds resettlement and adaptational experiences. Prior to use with participants, the interview schedule was shown to three professionals who worked with youth from refugee backgrounds (two psychologists and one case worker), and a member of the Sudanese community who ran a volunteer-based community services agency. It was also piloted with a small subgroup of participants ($n = 4$). Minor changes to the administrative procedures of the interview schedule were made following this period of consultation and piloting.

The YES-R consists of open-ended questions, designed to explore participants’ experiences of their refugee and resettlement journeys. Items were developed in line with the five major adaptive systems of the ADAPT model as follows, including interview sample items (Silove, 1999, 2013): Safety and security (*Safety System*; “Do you feel safe in Australia; do you feel safer in Australia compared to at home?”), maintenance of bonds and interpersonal relationships (*Attachment System*; “Who are people that provide you with support in Australia?”), effective mechanisms for administering justice (*Justice System*; “How do you think about what happened to you and your family at home and in your journey to Australia?”), capacity to perform roles and uphold identity (*Identity/Role System*; “What are your goals for the future?”), and ability to express aspirations that confer meaning (*The Existential-Meaning System*; “Do you think that holding religious beliefs has helped you deal with things both in your journey here and in Australia?”). Although the essence of the interview schedule was followed for all interviews, questions were used flexibly, and were adapted or omitted where indicated to promote individual participants’ agency over the interview process.

Posttraumatic stress disorder (PTSD) symptomatology. The Child PTSD Symptom Scale (CPSS; Foa, Johnson, Feeny, & Treadwell, 2001), a 17-item self-report inventory based on *DSM-IV* criteria, was employed to screen for symptoms of PTSD. The measure was designed to assess the presence and severity of PTSD symptoms in children and adolescents and has been applied to ethnically diverse populations (Jaycox et al.,

Table 1. Participant Demographic Characteristics at Time of the Interview

Demographics	Low group					High group				
	Kabira	Aela	Eniola	Hiwot	Kato	Catherine	Bageshri	Daara	Mbali	Dayo
Age	18	16	19	17	17	19	20	18	18	13
Sex	f	f	f	f	m	f	f	m	f	f
Birth country	Syria	Afghanistan	Rwanda	Rwanda	Rwanda	Congo	Bhutan	Afghanistan	Sudan	Uganda
Years residing in Australia	0.5	10	10	10	10	1.5	1	8	7	7
City of residence	Hobart	Melbourne	Hobart	Hobart	Hobart	Hobart	Hobart	Melbourne	Hobart	Melbourne
CPSS score	2	0	10	0	6	35	17	26	19	37
Familial living arrangements and separations	Parents, 2 siblings.	Parents, 3 siblings. 1 sibling at University, Sydney.	Parents, 3 siblings.	Parents, 3 siblings.	Parents, 3 siblings.	Parents, 2 siblings. 1 sibling at University, Brisbane; 1 in Africa.	Husband's family. Biological family in USA.	Parents, 3 siblings.	Mother, 2 siblings, Father and other siblings interstate/Africa.	Mother, 5 siblings. Father deceased. Other siblings with other families.

Note. Pseudonyms have been allocated and some specific details have been altered to maintain anonymity; f = female, m = male; CPSS = Child PTSD Symptom Scale.

2002; Jordans et al., 2010; Tol et al., 2008). The CPSS asks about the presence of PTSD symptoms over the past month on a 4-point Likert scale, yielding a total score ranging from 0 to 51. The measure has three subscales, which correspond to symptom clusters as reported in the *DSM-IV*: reexperiencing, avoidance, and arousal. A clinical cut-off score of 15, as recommended by the International Society for Traumatic Stress Studies (2013) for use with this measure, is indicative of a high level of PTSD symptoms. The scale has adequate internal consistency (Jaycox et al., 2002) and external validity (Foa et al., 2001; Kassam-Adams, Marsac, & Cirilli, 2010).

Procedure

The current study was approved by Monash University and University of Tasmania Human Research Ethics Committees and the Victorian and Tasmanian State Departments of Education and Early Childhood Development. Participants were recruited through the combined use of convenience and snowball techniques from consenting educational (two public secondary schools, an English language school, a Technical and Further Education Institution, and a university) and community-based institutions (a hospital-based refugee health clinic and a local GP practice) in Melbourne and Hobart, Australia. Written consent was obtained from all participants, and, where younger than 18 years of age, from their parents or guardians. Translated versions of consent forms were made available in numerous languages (including Arabic, Burmese and Karen). Phone interpreters were also made available in cases where no written translated consent form was available in the parents' or guardians' language and in instances where the participant reported that their parent or guardian was illiterate. A movie voucher was provided as an appreciation gift for participation in the study.

An initial pilot study was conducted with a small group of participants ($n = 4$) to test the feasibility of the study protocol. Only one participant chose to use an interpreter, despite the opportunity being offered to all. Interviews were conducted by the corresponding author, lasted between 30 and 90 min, and were audiorecorded, where participants gave written consent to do so.

Data Analysis

Qualitative data analysis. Audiotaped interview transcripts were transcribed verbatim by the corresponding author and a research assistant (who transcribed four transcripts, which were checked for accuracy by the corresponding author upon completion). Given English was not participants' first language, the data were edited only to enhance readability (e.g., incorrect usage of pronouns). NVivo 10 software (QSR International, 2012) was used for the coding of the data set.

Data were analyzed using thematic analysis, as detailed by Braun and Clarke (2013), which was also influenced by techniques utilized in interpretative phenomenological analysis (Braun & Clarke, 2013; Smith, Flowers & Larkin, 2009) with inductive, theoretical and experiential components all utilized in the analytic procedure. The ontological position underpinning this research was critical realism (Braun & Clarke, 2013); participants' accounts

of their experiences were taken as reality, but were considered in terms of pertinent historical, political, and cultural contexts in which they operated (Opperman, Braun, Clarke, & Rogers, 2014).

Data analysis was undertaken in accordance with procedures outlined by Braun and Clarke (2013). Data were analyzed over a series of stages. First, familiarization with the dataset was achieved through the first author transcribing and reading through the interview data. Second, transcriptions were read through again, and initial impressions on the data were written informally in memo form. Third, initial coding was undertaken at three levels (in analyzing the content of the transcript at a descriptive level, a semantic, and at an abstract or conceptual level) on each participant's transcript. Fourth, emergent themes were identified for each transcript, followed by the construction of subordinate themes based on connections and relationships between the transcript's emergent themes; both subordinate and emergent themes were named and defined. Steps 1 through 5 were undertaken for every participant. Finally, subordinate themes were reviewed across participants' transcripts to look for differences and commonalities at an individual, within-group level, and also across participants at a between-groups level. Subordinate theme titles were adjusted to reflect commonalities within and across groups. Themes were chosen particularly for their potency at a group level, and examined to see how they differentiated between groups. Themes that had particular salience within groups, and that differentiated from those in participants in the high group, were chosen for the analysis for the study. As is detailed in the results, this was done largely in terms of identifying themes that appeared to be of central importance to low group participants' adaptive psychological functioning, and were contrastingly not evident, or expressed in qualitatively different ways, by participants in the high group.

Results

Participant Demographics

The sample consisted of a total of 10 participants (8 females and 2 males) who had been in Australia on average 6.5 years ($SD = 3.99$, range = .5–10 years) and were aged between 13 and 20 years ($M = 17.5$, $SD = 1.96$). There were five participants in the high CPSS group (4 female, 1 male; mean CPSS score = 26.8, $SD = 9.07$), and five in the low CPSS group (4 female, 1 male; mean CPSS score = 3.6, $SD = 4.34$). Further demographic statistics are summarized in Table 1.

Thematic Analysis Results

The analysis detailed a number of themes that were common across accounts of participants in the low group's accounts, and were of marked contrast or absent in those of the high group. Themes pertaining to cultural belongingness and identification; psychological functioning; family unit functioning and relationships; and friendships and interpersonal processes were identified as having particular relevance for this study's participants, and in demonstrating particular contrasts between groups.

Cultural belongingness and identification.

Low CPSS group. This theme was pertinent to all members of the low group's accounts. With the exception of Kato,¹ all

participants upheld strongly felt connections to their homelands, and a sense of identification with, and belongingness to, their cultures and customs. Yet they were not completely resolute: Despite their strong ties with their homeland, participants also integrated aspects of Australian cultures and customs into their lives, and/or felt a sense of affiliation with aspects of Australian ways of life.

Hiwot, for instance, recalled her strong sense of connection to Rwanda upon returning to the country for a visit, "... you just feel really happy, like an overwhelming feeling of happiness and like you're supposed to be there. And really complete." Despite her ties with Rwanda and the resonance she felt with the way of life there, Hiwot believed that establishing ties to Australia was also important. She reported that she tried to learn about aspects of the Australia culture and, "... still keep my own culture but learn and integrate as opposed to completely shutting off one side." Eniola also endorsed a similar sentiment when giving advice to others coming to Australia from similar backgrounds. She spoke of the importance for people not to lose ties to their cultural background when partaking in aspects of Australian culture, "... I just think integrate the two cultures ... just have like a middle ground where you think well if I was where I am coming from, would I think that this is okay?"

Unlike the other participants of the low group, Kato demonstrated a strong sense of belongingness to Australia, as opposed to his birth country, Rwanda. He spoke keenly about how he enjoys aspects of the Australian culture, such as Australian Rules Football (AFL), and how he has always felt a sense of belongingness with Australia, as opposed to Rwanda. His felt "culture clash" he reported experiencing when he went back to Rwanda to visit relatives can be contrasted to his feelings about Tasmania (the state of Australia that he moved to and has stayed living in upon arriving to Australia). "I've always recognized Tassie [Tasmania] as my home." For Kato, it appears that this sense of belongingness has come from his growing up considering himself as a typical Australian, as one of many who come to the country from a range of migrant backgrounds. For Kato, there was never any reason for him not to identify with being an Australian, as his quote regarding this topic emphasizes, "It's what I know, it's what I am."

High CPSS group. In stark contrast to the low CPSS group, participants in the high CPSS group did not evidence strong ties to either their homeland or Australia. Unlike those of the low group, participants did not volunteer much information about their homelands, and appeared to maintain few ties and connections to their respective birth countries. Catherine, for instance, reported prior to the interview commencing that she did not wish to talk about things that had happened to her in the past, and, therefore understandably, volunteered little information about her home country. In a similar vein, when asked if she had ever considered going back to Sudan, Mbali answered, "I never thought about that. I never think about it, I hardly do." Also in contrast to the low group, participants did not evidence connections or identification with Australian culture either. Daara for instance, reported that,

¹ All names and other identifying information have been changed to protect participants' anonymity

despite being in the country for 8 years, Australia still felt like a “foreign country” to him.

Psychological functioning.

Low group. Insight into the nature of members of the low group’s psychological functioning, including reflective capacity, goal-directedness and ideological commitments, could be gleaned from their accounts. Participants were generally introspective, and demonstrated a high level of psychological insight particularly when discussing their thoughts pertaining to their and their family’s experiences as refugees. They further demonstrated a developed capacity to jointly think about and plan for their future, particularly regarding their educational and career goals. Further, participants held strong and well-formed moralistic beliefs and values, of which many of them reported trying to live their lives by.

Upon considering their past status as refugees and their families’ resettlement in Australia, participants generally demonstrated an ability to find meaning out of their situations and to be reflective as to how the events impacted upon them. In particular, they showed a propensity to compare themselves to others who they thought of as being less fortunate, and conclude that they in fact were “lucky” (to use Aela’s terms). Kabira, for example, spoke about her gratitude upon being allowed entry into Australia with her entire family, comparing her situation to fellow Syrians who had remained in the country:

Thank God because I am here. I’m safe now, my and my family together, not like another people. Another people, the daughter is kept but her family no, her parents not. So everybody in Syria is maybe separate. But I stay with my family.

Hiwot also compared her situation to that of her family’s, and also demonstrated tendency to normalize her situation in the following account:

. . . ask anyone from Africa, most African countries have been in some conflict or another. Not at the same rate, obviously, some things are worse than others. But so that was just the norm . . . to understand that your family . . . had lived through something, but back then we were so young, and coming to school it was easy for us . . . But now that we’re older we look back and think how hard it would have been for the adults of our family, who knew, who had the history.

Having confidence in their choices regarding their future life directions was an overarching trend for the low group’s participants. Although many were yet to solidify their future plans, they demonstrated a clear sense of the direction they wished their lives to take, particularly with regard to their educational and career goals. Aela, for instance, spoke enthusiastically about how she wished to pursue a degree in psychology upon completing her schooling, and had already begun to think about the preparations she would need to make prior to her course commencing, “You know how year 12 finishes and you get a big holiday? During that time I’m going to work and I will prepare myself for uni. If I get an offer, I will prepare for that . . . get all the things I will need.” While Eniola was clear in her convictions that she wished to stay living in Tasmania for the near future, despite some of her peers perceiving it to be an unfashionable decision, “I do not have to do what everyone [else] wants to do.” Finally, Kabira demonstrated a likely propensity to face difficulties with an optimistic yet realistic

attitude, and an aptitude to think of alternate options when faced with barriers. Her account detailing her plans for attending university in another country should she not be able to get in to an Australian institution illustrates this, “I said to my Mum . . . if I cannot go to university next year [in Australia], then maybe I study for 2 years or going to Arab country to complete my study.”

Participants of the low group were also confident, and at times expansive, in discussing the ideals and morals by which they strive to live their lives. Kato described how the church “modeled” his moral beliefs and interpersonal behaviors, “. . . I guess like being grateful and like it’s basically morals, like being nice to people . . . The church has sort of emphasized it so yeah I’ve just always followed that and done that.” Likewise, Aela conducted her life according to religious ideals and stated, “For me my religion is a big part of me and I support my religion in every way. I would never do something that goes against my religion.”

High group. Participants in the high group did not discuss topics concerning their own psychological functioning as much as those in the low group. There was a further contrast in how they thought about and articulated their future plans, as well as an absence of discussion around their moralistic and life values.

Unlike the low group, participants in the high group discussed how they utilized avoidance-based mechanisms when dealing with stressors. Daara, for instance, described how he avoided interacting with his family members upon arriving home, because of fractious relationships between himself and his father, “That’s why I just go home on my laptop. I just talk with my mates, or watch movies.” Mbali described her tendency to avoid talking about emotionally uncomfortable topics, “I’m not really the type of person who says how I feel, so I just keep everything inside.” In line with these findings, participants generally discussed little in the way of their inner emotional worlds.

Regarding their future plans and goals, participants often spoke vagaries, with the exception of Catherine, who had clearly established future educational and career plans (although her future thinking process regarding other aspects of her life were comparably unclear). Although Dayo and Mbali reported that they had careers in mind upon leaving school, they were less detailed about the motivations for why they wished to pursue these career paths, and less expansive in their discussions about the topic than those in the low group. Mbali reported that she wished to be a history teacher, however did not evidence a clear plan for how to go about doing this, either in terms of the academic subjects she reported she had yet to choose for her year-12 subjects, nor in terms of a plan for undertaking university studies. Bageshri also evidenced a sense of uncertainty with which direction to take in her future studies and career pathway:

(laughs) in Tuesday, the teacher came into the class and he was teaching us like our career (laughs). He just [asked] questions, like what do you want to do in the future, blah blah blah. But I don’t know. I do not know in which course, in which field I am good. Still I do not know.

Finally, unlike those in the low group, high group participants did not evidence thinking about moralistic or ideological beliefs and values. Instead, some participants, like Daara, evidenced a lack of clarity regarding their thoughts on such matters. Daara reported that he used to be involved with gang activities, where he and fellow members got into fights with

other youths. During this time, Daara said he, "always thought to myself, what am I doing, is that . . . right or wrong?" This account indicates that in some sense he felt that what he was doing was morally wrong (he also reported that he has distanced himself from these peers, stating, "I actually try my best not to see them, like ever," providing further support for this supposition), however his account demonstrates that he was not entirely sure about where he stood on the matter. There was minimal content from the accounts of the other participants in the low group pertaining to this theme.

Family unit functioning and relationships.

Low group. Participants in the low group, with the exception of Kato,² expressed strong intrafamilial relationships and connections. Family was conveyed as being of central importance to participants' lives. Participants also evidenced a shared sense of history with their families, they were largely aware of, and open in discussing, their family's refugee experiences. In line with this shared history, participants evidenced open lines of communication between themselves and their parents, and there were clear delineations and mutual understandings of people's roles within the family unit, as they pertained to things like housework and chores. It is important to note that every participant in the low group lived in Australia within an intact family unit (i.e., with both parents and siblings), as this may have been a factor that would have contributed to the above mentioned processes.

Participants often spoke in collective terms when discussing their refugee and resettlement experiences, indicating that it was something they perceived they went through as a family together. For example, Aela, who arrived in Australia as an asylum seeker, said, "Well we did have a bit of a rough patch when we first came here because we came by boat and when we were on the seas it was quite hard for us." In a similar sense of family togetherness, Kabira indicated that while she finds it difficult to be in Australia without her Syrian friends, she now engages in joint social activities with her family instead, ". . . because I don't have friend to [go] out with them, when we are going we always with my Mum or my sister . . . I have fun with my family."

Although it was not something the interview focused on, participants spoke openly of their and their families' history as refugees. Kabira, for example, spoke of her intergenerational history of refugeedom, stemming from when her grandparents fled from Palestine to Syria, "My grandfather, he said to us, 'I don't leave another country, not like I did before' . . . because my grandparents, they left Palestine." Similarly, Eniola spoke about the way in which her family protected her from the impact of Rwanda's genocide, ". . . my parents tried really hard, 'cos I think after the genocide I was really traumatized and apparently when I saw people hug I burst into tears. So like they tried to shield us from that."

High group. In contrast to the low group, participants in the high group evidenced disruptions and difficulties within the family unit. There was also generally a lack of comparative openness in discussing their family's shared history, both in general terms and as it related to their refugee histories (with the exception of Dayo, who discussed the topic in great detail). For some participants, like Daara and Dayo, there were conflictual relationships between

family members, while others, like Mbali and Bageshri, were dealing with the impact of familial separations and attachment disruptions. It is important to note that four of the five participants in this group had been residing in Australia with members of their immediate family who now were either deceased or residing in other countries (see Table 1). Unlike those in the low group whose families were intact, the impact of these separations appeared to be keenly felt by participants.

In stark contrast to the way in which members of the low group discussed their family relations, Catherine said, when discussing her family and the prospect of her moving away from them, "It's not that it's [family] is very important, I have a great attachment to my family because I've never been away from them." Catherine's statement expresses contradictory thoughts about her family, and appears to on the one hand value family attachments, yet concurrently minimize their importance. While also in contrast to participants from the low group, Daara evidenced quite a pronounced sense of disrupted familial bonds. He stated of his older stepbrother, "I hate him so much"; his home-life in general, "when I go home I just do not feel right"; and that his Dad ". . . doesn't like the way I am."

As mentioned, familial separations appeared to have a substantial direct, as well as flow-on effects on participants and their families. Bageshri, for instance, had moved to Australia with her husband, while the rest of her family unit had been granted refugee status in the United States of America. The emotional impact of this separation on Bageshri appeared to be very difficult for her to cope with, as she tearfully described in the interview, ". . . [it is] very hard. I miss my Mum and my family, but I miss my Mum so much." Dayo spoke openly and in detail about her family's refugee history, commencing when her father died in Uganda when she was an infant. She described living in a refugee camp characterized by transience and upheaval. Because of having a very large family and having only her mother as the primary caregiver, Dayo's mother had to leave the camp on many occasions to find work, leaving Dayo and her siblings living with various family members and family friends. Even upon resettlement in Australia, the effects of having only one primary caregiver still had impact upon Dayo and her family members, and the family had to be separated again (with two children moving to live with other people), because of her mother finding it "too hard to take care of all of us." The impact upon this separation of family members has resulted in changes to Dayo's family hierarchy. She spoke about having to now undertake many more chores around the house as a result of her sisters leaving, often leaving her feeling "frustrated" and resulting in arguments with her mum. Finally, for Mbali, whose father had remained in Sudan, there appeared to be a sense that she had moved on from this relationship. She stated, "Dad is not here as well, he is in Africa . . . he has three other wives to look after, so yeah." Mbali's lack of emotion in this account perhaps indicates her feeling that her father is no longer a part of her life, particularly given that he has other obligations to "look after" his wives back

² Kato's interview was conducted in his family home, and his father was sitting in an adjacent room at the time of the interview. This may partly explain Kato's lack of discussion around family issues in the interview.

in Africa; indeed, Mbali later said that she has not spoken to her father for some years.

Friendships and interpersonal processes.

Low group. The theme of friendships and interpersonal processes could be applied to most participants of the low group's interviews. From those who discussed the topic, it was clear that friendships were important to them, and they took particular value in having peers from differing social circles and backgrounds.

Of his friendships, Kato said, "I love hanging out with my mates." He valued the fact that he had friends from a variety of social circles, and appeared to be confident and self-assured in his capacity to form and maintain relationships with a variety of people:

I've got mates from church and school . . . Yeah the mates that I have from church are kind of different from my school mates. My school mates are like footy, and like Australian blokes and the ones from church aren't, but yeah I sort of like that.

Similarly, Eniola and Hiwot described having many Australian school friends, but valued the fact that they did not get involved in their peers' tendencies to only being friends with people from certain "groups." Hiwot, for example, said, ". . . you speak to people who are in like the whole group, not so popular, right through to the people who are very popular, you do not discriminate." Eniola appeared to take pride in the fact that she formed friendships with those who were looked down upon by her peers, ". . . I just remember everyone bullying her . . . through school and I was the only [one] who she could talk to. Sometimes I just used to ignore everyone and just go sit with her."

Kabira, on the other hand, spoke about her difficulties with peer relationships in Australia. She reported that she found it difficult to fit in both with Australian people and with her classmates, who also share refugee backgrounds, but are from a variety of non-Arab countries, ". . . it's hard because I do not know about Australia . . . I don't know how I can talk with them [Australians] . . . or, for another refugee, like Nepal or Sudan . . . I don't know about them." Yet she still maintained strong ties with a close group of her Syrian friends, something that she indicated was helpful when she was having difficulties in adapting to life in Australia, as is illustrated in the following quote:

Yes, so it's hard. But sometimes I can work with that, because I try to go with my friends in Syria and talking with them [on] skype. Sometimes I'm not worried about that because my friends still stay with me.

High group. With the exception of Dayo, who spoke in affectionate terms about her friendships, and Bageshri, who largely did not discuss the topic, the nature of interpersonal relationships and friendships of the other participants in the high group was qualitatively different to those in the low group. The accounts of Catherine and Mbali pointed to their possible social isolation, and while Daara reported that he valued his friendships highly, they were characterized as being transitory in nature.

Catherine evidenced particular difficulties with interpersonal relationships, particularly since arriving in Australia. Although she involved herself in various community groups and activities designed for young people her age, in a possible attempt to form meaningful interpersonal connections, she found her school peers

were reticent to form relationships with her, ". . . the first days it was very hard for me to find friends, and talk to people. For example, some students like looked down upon me, like they couldn't accept that I could do anything or that I could achieve anything." Mbali also experienced difficulties upon first arriving in Australia with her school peers, and spoke about how she had been bullied by others. Mbali's following account demonstrates her sense of vulnerability and alludes to her experience of significant stressors prior to coming to Australia. That she was then bullied by her peers subsequent to these experiences appeared to have compounded the impact:

Corresponding author: What do you think the biggest issues, or the biggest challenges are for young people who come to Australia from a refugee background?

Mbali: . . . I think mainly fitting in with the others, [the other] kids. Like, um no one really understands what you've been through . . . so like sometimes they say stuff or mean things, and they don't really know it gets to you.

Following the above quote, she went on to further say about her experience of being bullied, "Cos you've already been through a lot, you don't want to go through a lot again."

Discussion

The present study's findings provide a rich account of some of the differentiating factors between select groups of youth from refugee backgrounds with high and low levels of PTSD symptomatology. Whereas there was individual variation in participants' accounts, in general terms, the groups were distinguishable in the nature of issues they faced in the resettlement environment and in the way in which they dealt with and thought about them. Participants in the low group were characterized by their strong sense of cultural belongingness and identity; this was largely felt toward their respective homelands, with the exception of Kato, who reported a strong sense of belongingness to Australia. They were self-reflective and insightful, and most found meaning out of their refugee experiences. They further demonstrated strong senses of moral beliefs and life values. The low group's core family units were intact, with family relationships characterized by affection and mutual understanding. Finally, participants in the low group generally demonstrated strong interpersonal bonds with peers from a variety of backgrounds.

In comparison to the low group, the content of the themes pertaining to the high group were generally of a starkly different nature. Participants in the high group generally did not discuss issues of cultural belongingness, to either Australia or their home countries, and of those who did discuss the topic, it was in terms of a felt disconnection. High group participants generally did not appear to engage in thinking reflexively about their past experiences as refugees, nor did they speak in detailed terms about their life or moralistic values. Instead, their thinking processes tended to be focused on present-day concerns and stressors, and many appeared to use avoidant coping mechanisms when dealing with these stressors. The low group's family units were characterized by familial separations and, for one participant, acrimonious and conflictual relationships. Finally, while clearly being an important part of their lives for some, interpersonal relationships largely did not have the same resonance for participants in the high group

compared to those in the low group. Two participants in particular also had experienced pronounced interpersonal difficulties in the form of bullying and discrimination in their resettlement countries.

Participants with low levels of PTSD symptomatology in this study clearly perceived the importance of upholding a sense of connection with and belongingness to community. In likeness to other qualitative studies with resettled refugee youth (Gifford, Correa-Velez, & Sampson, 2009; Valentine, Sporton, & Nielsen, 2009) and adults (Keyes & Kane, 2004), for the majority of the participants in the low group, this identification and belongingness was felt toward their ethnic communities and homelands. Participants with high PTSD symptom levels, in contrast, largely evidenced a disconnect, not only from their homelands but also from aspects of Australian culture.

Early theorists wrote of belongingness as being a basic human need (Maslow, 1954; Thoits, 1982), while writings on the concept of psychology of place have postulated that displacement may result in psychological difficulties because of the disruption of processes of place identity, familiarity, and attachment (see Fullilove, 1996, for a review). Results from empirical research provide further evidence for the importance of this concept in refugee adolescents. In another study with resettled refugee adolescents in Australia, Kovacev and Shute (2004) found that those who had the most positive attitudes toward both Australian and their ethnic cultures had the highest self-worth and peer acceptance ratings, compared to those with negative attitudes in both domains. After going through the experience of being refugees, wherein ties and attachments to place are profoundly disrupted (Silove, 1999), maintaining a sense of connection and belongingness to place appears to be highly protective. While belongingness and attachment to place is not explicitly mentioned in the ADAPT model (Silove, 1999, 2013), it could be conceptualized as fitting with the model's attachment system, where Silove asserts that losses and trauma are experienced not only at the individual level, but at a communal level also. It may be, therefore, that adolescents who fail to maintain and/or develop a sense of belongingness to community and place following their experiences as refugees will be more likely to develop psychological difficulties as a result. Indeed, participants in the high group demonstrated that this is an aspect of their lives that is disrupted, and, although directionality cannot be established from this study's findings, it may be that this is impacting upon their psychological difficulties.

Certain coping processes and the maintenance of ideological commitments have been found to be protective against psychopathology in refugee populations (Fazel et al., 2012; Lustig et al., 2004). That participants in the low group demonstrated using a variety of coping and, apparently, adaptive cognitive processes (such as their maintenance of strong moral and ideological beliefs) is perhaps illustrative of this notion. Optimistic thinking, problem-solving, normalization, and ability to consider stressors from others' perspectives, all of which were evidenced by participants in the low group, have been found to relate to positive psychological outcomes (Ai, Tice, Whitsett, Ishisake, & Chim, 2007; Compas, Connor-Smith, Saltzman, Thomsen, & Wadsworth, 2001). In comparison, there were some participants in the high group that demonstrated a tendency to avoid thinking about potentially difficult topics. Though some adult refugee studies have found avoidance coping to be related to increased PTSD symptom levels (Ai et al., 2007; Finklestein & Solomon, 2009; Huijts, Kleijn, van Emmerik,

Noordhof, & Smith, 2012), it is important to also note that in some non-Western cultures avoidance of emotional expression and disclosure is considered adaptive and protective (Burnett & Peel, 2001; Summerfield, 1999). Clearly more research in this area would be of benefit.

Further preliminary evidence indicates that the maintenance of religious and ideological commitments is protective to resettled refugee youth (Goodman, 2004; Montgomery, 2008; Servan-Schreiber, Lin, & Birmaher, 1998); that most participants with low PTSD symptom levels discussed holding such beliefs provides further evidence that such processes may relate to positive mental health outcomes, and indeed align with the ADAPT model's (Silove, 1999, 2013) conceptualization of the existential meaning system, which posits that individuals require a coherent narrative and belief system to make sense of their lives. Although the relationships between refugee trauma, psychological functioning, cognitive processes, and ideological beliefs are undoubtedly complex (Fazel et al., 2012), this study provides important detailed accounts of the role that these processes play in many refugee adolescents' lives.

That the family unit played a significant role in both groups' accounts was to be expected, given that the refugee experience often imparts profound disruptions to families' makeup and functioning (De Haene et al., 2007; Gifford et al., 2009; McMichael, Gifford, & Correa-Velez, 2011), and because of the importance of the family to adolescents generally (Parke & Buriel, 2008; Matlin, Molock, & Tebes, 2011). Accounts from the low group's participants indicated their families' centrality to their lives, and the important protective roles their family, particularly their parents, played during refugee and resettlement experiences alike. These findings are in concert with other studies with refugee youth that demonstrate that responsive and supportive caregiving as an important protective factor in young refugees' mental health (De Haene et al., 2007; Fazel & Stein, 2002; Gifford et al., 2009; Hodes, 2002; McMichael et al., 2011). These results further concur with studies demonstrating that specific familial factors such as family unity (Panter-Brick, Grimon, & Eggerman, 2014), and parental processes such as having a loving and strong parent-child relationship (Afifi, Afifi, Robbins, & Nimah, 2013; Qouta, Punamaki, & El Sarraj, 2008) and attentive and emotionally supportive parenting (Thabet, Ibraheem, Shivram, Winter, & Vostanis, 2009), play protective roles in young refugees' mental health. Being separated from family members and resultant changes in familial structures and hierarchies is a common experience for refugee families (Gifford et al., 2009; Walter & Bala, 2004; Weine et al., 2004), and one that occurred for participants in the high group. In concert with other studies, findings from the present study demonstrated that such separations had significant effects on adolescents (such as in the impact of changed familial roles and responsibilities and family structure) that continued well into the resettlement years (Gifford et al., 2009; McMichael & Manderson, 2004; Nickerson, Bryant, Steel, Silove, & Brooks, 2010; Weine et al., 2004). The results pertaining to the importance of the family unit demonstrate the importance of interpersonal and social processes in people's recovery and adaptation following refugee trauma (Silove, 1999, 2013). Indeed, as Silove (2013, p. 241) writes, "... restoring the integrity of interpersonal bonds and wider social supports is vital to promoting recovery . . . following

exposure to conflict." Family is likely to be of central importance in such processes.

In likeness to the findings regarding the family unit, participants' accounts as they pertained to friendships and interpersonal processes give qualitative insights into established results from the quantitative literature, and again back up Silove's (1999, 2013) assertions regarding the protectiveness of interpersonal bonds and networks after trauma. The protectiveness of supportive social relationships is a well-established finding in the refugee literature (Fazel et al., 2012; Lustig et al., 2004), and participants from the low group demonstrated that they had well-established, mutually supportive interpersonal relationships. Participants from the low group also spoke about how they maintained relationships with a variety of people, both with ethnic peers and also, in most cases, with Australians. Such processes were demonstrated to relate to wellbeing outcomes in a study with adolescents in one of London's multiethnic communities (Bhui et al., 2005), wherein fewer mental health problems were demonstrated among adolescents who had friends from a range of cultural groups. Participants in the high group on the other hand, demonstrated transient interpersonal relationships and being victim to bullying and discrimination, an established correlate of negative mental health outcomes in resettled refugee populations (Fazel et al., 2012; Pedersen & Thomas, 2013; Shedlin, Decena, Noboa, & Betancourt, 2014).

Although the groups in the present study were small, the stark contrasts in accounts between those who had high levels of PTSD symptomatology versus those with low levels is notable. The findings from this study provide important evidence for the need to broaden our conceptualization of the impact of the refugee experience away from a purely individualistic one, and strongly support the assertions made by Silove (1999, 2013) in his ADAPT model. The family unit's functioning was a major factor that distinguished the two groups in this study. Although there is a dearth of research examining how specific familial factors act in the etiology of distress in refugee populations (De Haene et al., 2007; Fazel & Stein, 2002; Weine et al., 2004), this study backs up established evidence attesting to the family unit's centrality in the lives of adolescents. Interventions that focus on strengthening family relationships, particularly in those who have family separations, appear to be warranted. This study further demonstrates that interventions focusing on promoting adolescents' sense of cultural and social belongingness may also be warranted in refugee populations. Overall, high group participants were experiencing multiple stressors concurrently across different areas of their lives. The use of multimodal interventions, wherein difficulties at an individual, familial and sociocultural level are addressed (Nickerson et al., 2011), seems particularly worthwhile for these adolescents, and present an avenue for promising further research as to their efficacy in such populations (Tyrer & Fazel, 2014).

This study has several limitations that are of note. First, the sample size was small. Though this facilitated a detailed and idiographic analysis, results must be interpreted with caution given the low numbers. That the interview was conducted and interpreted by a Caucasian ethnic Australian may have had an effect on the nature of participants' responses, and also in the way in which the data were interpreted. Although the data analysis and sampling procedures were conducted with sensitivity to cross-cultural issues, it is impossible to tell if these factors did indeed play a role in the research process and findings. Further, selecting the most

detailed interviews for inclusion in this study may have skewed the sample toward older participants, who are likely to be more inclined to be open and reflective in discussing their experiences than younger children and adolescents. The lead author was responsible for both data collection and data analysis, and hence was aware of the level of PTSD symptomatology for participants when coding was undertaken. Though researchers external to the project were used to cross code data, the possibility that there may have been interpretative bias from the lead author remains.

Despite these limitations, findings from this study provide rich and detailed first-hand accounts of the issues faced by young people from refugee backgrounds in their resettlement, and also on the idiographic way in which their refugee and resettlement experiences are conceptualized. The marked differences in the issues faced and the way in which experiences were discussed by adolescents in each group provide important clues as to the possible correlates and protective factors implicated in psychopathology, perhaps PTSD in particular, in adolescents from refugee backgrounds, and provide important avenues for future enquiry into the condition in adolescents from refugee backgrounds.

Keywords: refugees; adolescence; PTSD symptomatology; belongingness; familial relations; peer relations

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Psychological Distress Among Victimized Women on Probation and Parole: A Latent Class Analysis

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Latent class analysis was used to identify subgroups of victimized women ($N = 406$) on probation and parole differentiated by levels of general psychological distress. The 9 primary symptom dimensions from the Brief Symptom Inventory (BSI) were used individually as latent class indicators (Derogatis, 1993). Results identified 3 classes of women characterized by increasing levels of psychological distress; classes were further differentiated by posttraumatic stress disorder symptoms, cumulative victimization, substance use and other domains of psychosocial functioning (i.e., sociodemographic characteristics; informal social support and formal service utilization; perceived life stress; and resource loss). The present research was effective in uncovering important heterogeneity in psychological distress using a highly reliable and easily accessible measure of general psychological distress. Differentiating levels of psychological distress and associated patterns of psychosocial risk can be used to develop intervention strategies targeting the needs of different subgroups of women. Implications for treatment and future research are presented.

Women are among the fastest growing segment of the correctional population. At present, over 200,000 women are incarcerated and more than 1 million women are on probation (Ajinkya, 2012). Approximately one of every 89 women in the United States is involved in the criminal justice system and more than 85% are sanctioned within the community (i.e., probation, parole; Glaze & Bonczar, 2011; Greenfeld & Snell, 1999; Sabol & Couture, 2008; Shilton, 2000).

Among justice-involved women, psychological distress, substance use and violent victimization are intersecting epidemics that present a serious threat to public health and functioning. Research

has consistently documented rates of psychological distress among justice-involved women that exceed both their male counterparts and women in the community (Green, Miranda, Daroowalla, & Siddique, 2005; Jordan, Schlenger, Fairbank, & Caddell, 1996; Lynch, DeHart, Belknap, & Green, 2013; Steadman, Osher, Robbins, Case, & Samuels, 2009; Teplin, Abram, & McClelland, 1996). In a study examining the prevalence of serious mental illness (e.g., major depressive disorder, bipolar disorder, schizophrenia spectrum disorder) among people in five jails, 31.0% of females were found to have a current serious mental illness as compared with 14.5% of the males (Steadman et al., 2009). Similarly, in a national survey of women randomly sampled from urban and rural jails, 43% and 32%, respectively, met the lifetime and 12-month criteria for a serious mental illness (Lynch, DeHart, Belknap, & Green, 2012b; Lynch et al., 2013). High levels of posttraumatic stress disorder (PTSD) are also found among females detained in jail. Estimates indicate that approximately a quarter of women in jail meet the criteria for a current PTSD diagnosis (Green et al., 2005; Teplin et al., 1996); 53% have a lifetime diagnosis of PTSD (Lynch et al., 2012b; Lynch et al., 2013).

Incarcerated women with mental health problems are 3 times more likely to experience addiction than those without such problems (James & Glaze, 2006). Rates of co-occurring substance use and psychological distress range from 39% to 46% among women in jail (Lynch et al., 2012b; Lynch et al., 2013). In fact, substance abuse and dependence are the most common psychiatric disorders among women in the justice system. Among women in jail, lifetime prevalence of substance use is between 70% and 83% (Jordan et al., 1996;

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Lynch, DeHart, Belknap, & Green, 2012a; Teplin et al., 1996); they are almost 9 times more likely to experience substance abuse or dependence than a comparison group of women in the general population (Jordan et al., 1996; Teplin et al., 1996).

Compounding issues of psychological distress and substance use are histories of interpersonal victimization; up to 80% of women in the criminal justice system have experienced some form of victimization in their lifetimes (Browne, Miller, & Maguin, 1999; El-Bassel et al., 1996; Green et al., 2005; Greenfeld & Snell, 1999; Lynch et al., 2012b; Lynch, Fritch, & Heath, 2012; McClellan, Farabee, & Crouch, 1997; Owen & Bloom, 1995; Reichert, Adams, & Bostwick, 2010). For example, in a study involving jailed women with substance use histories, 25% of women reported sexual abuse as children (El-Bassel et al., 1996). Another study with incarcerated women found that 57% reported childhood victimization and 75% reported adult victimization (McClellan et al., 1997).

While current research has documented the significance of psychological distress, substance use and victimization in the lives of justice-involved women (Bloom, Owen, & Covington, 2003, 2004; Daly, 1992; Hall, Golder, Conley, & Sawning, 2013; Salisbury & Van Voorhis, 2009), there remain significant gaps in understanding regarding the relationships among these factors and their implications for practice and policy. In particular, the emphasis on the overall prevalence of these issues obscures the heterogeneity that exists among women in the justice system. The identification of risk profiles among subgroups of justice-involved women has yet to be explored and may illuminate various, complex elements that affect women's behavior (Reisig, Holtfreter, & Morash, 2006). Establishing risk profiles provides the opportunity to empirically classify subgroups of women based on intersecting characteristics, which can guide the development of targeted, evidence-based risk assessment and management protocols and concomitant intervention and prevention strategies (Lanza & Rhoades, 2013).

To address this need, this investigation applied latent class analysis (LCA) with a sample of victimized women on probation and parole. The present study sought to explore whether indicators of general psychological distress could be used to identify distinct subgroups of victimized women on probation and parole and to compare these groups across external indicators of PTSD, cumulative victimization, substance use and other domains of psychosocial functioning that are associated with engagement in high risk behaviors (Nyamathi, 1989). Comparisons across the external indicators serves several purposes: (a) validation of the identified subgroups by confirming the between-groups differences; (b) further elucidation of the substantive meaning of the subgroups; and (c) provision of a more nuanced understanding of the intersections of psychological distress, victimization, substance use and other psychosocial domains among women on probation and parole. As an exploratory study, there were no a priori hypotheses regarding the number of possible subgroups or differences and similarities that might arise among the identified subgroups.

Method

Participants and Procedures

The study sample ($N = 406$) was drawn from women on probation or parole or both in Jefferson County, Kentucky, an urban area that includes Louisville. Participants were recruited by

outreach, direct mailings to women on probation and parole in Jefferson County, flyers, word of mouth, Internet, and TV and newspaper advertisements from July 2010 to January 2012. Eligibility criteria required (a) being on probation or parole in Jefferson County; (b) being at least 18 years old; (c) reporting sexual involvement with men only or with both women and men; and (d) reporting any lifetime experience of physical or sexual victimization or both. Eighty-one percent of the women screened were eligible to participate; the final study sample represented approximately one fifth of all women on probation and parole in Jefferson County at the time recruitment was initiated (Kentucky Department of Corrections, Division of Probation and Parole, personal communication, November, 5, 2010.). Following provision of written informed consent, all interviews were administered in person by trained female staff using audio computer-assisted interviewing (ACASI; NOVA Research Company, 2003). This study was approved by the University of Louisville Institutional Review Board; an National Institutes of Health Certificate of Confidentiality was obtained.

Data Analysis

The LCA was performed with Mplus 6.0 software; model parameters were estimated via maximum likelihood procedures (Muthén & Muthén, 1998–2007). A series of models was estimated beginning with one class and incorporating additional classes until an optimal solution was obtained. Fit indices and the substantive meaningfulness of the models were evaluated to determine the optimal solution (Muthén, 2003). Model fit was assessed using Bayesian information criteria (BIC), whereby a lower BIC value represents better model fit; sample-size adjusted BIC (ABIC); log likelihood value (LL); posterior probabilities; and entropy values (from 0 to 1 for each model; Everitt, Landau, & Leese, 2001; Nylund, Asparouhov, & Muthén, 2007). The bootstrap likelihood ratio test (BLRT) was used to confirm the final number of classes (Nylund et al., 2007). Chi-square analyses examined associations between each of the classes and external variables.

Measures: Latent Class Indicators

The nine primary symptom dimensions (somatization, seven questions; obsessive–compulsive, six questions; interpersonal sensitivity, four questions; depression, six questions; anxiety, six questions; hostility, five questions; phobic anxiety, five questions; paranoid ideation, five questions; and psychoticism, five questions) from the Brief Symptom Inventory (BSI) were used individually as latent class indicators of general psychological distress (Derogatis, 1993). Scores were calculated by computing the mean of the questions for each symptom dimension, which had a range of 0 to 4, reflecting how bothered or distressed a participant was by the particular symptom from 0 (*not at all*) to 4 (*extremely*). Alpha reliabilities in the present sample ranged from .80 for paranoid ideation to .91 for depression.

External Variables

Sociodemographic characteristics and correctional status. Respondents' age was provided in years. Race or ethnicity of the participants was described as: Black, non-

Hispanic; White, non-Hispanic; and other (Latina, Asian/Pacific Islander, Native American, multiracial, and other). Intimate partner status was assessed by three categories indicating whether a respondent reported being single, married or cohabiting with a sexual partner of the opposite gender, or being divorced, separated, or widowed at the time of the interview. Five categories described educational attainment: less than a high school diploma/GED; high school diploma/GED; trade/technical training; some college/college graduate; some graduate school/graduate school degree. Current employment status was operationalized as unemployed, employed full or part time, unemployed because of disability, in school only, or "other." Finally, women were asked if they considered themselves homeless (yes = 1; no = 0).

Correctional status was assessed by asking women whether they were on probation, parole, or both. Questions adapted from the Addiction Severity Index were used to assess whether participants had been in a controlled environment or halfway house or recovery home in the past 12 months (yes = 1; no = 0) and, if so, the number of days that they had been in a controlled environment during that time (McLellan et al., 1992).

Posttraumatic stress symptoms. The Posttraumatic Stress Diagnostic Scale was used to operationalize four indicators of posttraumatic stress (PDS; Foa, 1995; Foa, Cashman, Jaycox, & Perry, 1997; Sullivan, Cavanaugh, Buckner, & Edmondson, 2009). The first indicator assessed whether or not any traumatic events occurred according to DSM diagnostic criterion (American Psychological Association, 2000). The second indicator measured the severity of reexperiencing, avoidance or numbing, and arousal symptoms (i.e., sum score of the severity of 17 symptoms; possible range: 0–51; $\alpha = .94$). The third indicator reflected the number of life domains in which functioning was impacted by symptoms (possible range: 0–8). The PDS may be utilized as a diagnostic screening tool for PTSD; as such, a final indicator was included to assess whether or not (yes = 1; no = 0) the woman met the diagnostic criteria for PTSD.¹ Although there is conceptual and statistical overlap between this final indicator and the other variables operationalizing this domain, this variable was included to provide an understanding of the proportion of respondents who met the diagnostic criteria for PTSD and to increase the interpretability and utility of the results (Golder, Connell, & Sullivan, 2012).

Cumulative victimization. Cumulative victimization was described by three categories of violence assessing childhood abuse and adulthood intimate and nonintimate partner victimization (IPV; NIPV). Victimization questions were adapted from the National Crime Victimization Survey and IPV literature, including the Revised Conflict Tactics Scale and Tolman's Psychological Maltreatment of Women Inventory (Straus, Hamby, Boney-McCoy, & Sugarman, 1996; Tjaden & Thoennes, 1998, 2000; Tolman, 1999, 1989), and have been used in prior research (Golder & Logan, 2010, 2011, 2014; Logan & Leukefeld, 2000; Logan, Walker, & Leukefeld, 2001). For each of the victimization categories, three subtypes of victimization (i.e., psychological, physical, sexual) were examined, with the exception of NIPV, where

only physical and sexual victimization were assessed. Two variables were used to measure each of the subtypes of victimization: (a) a dichotomous measure (yes = 1; no = 0), indicating whether or not this type of abuse ever occurred; and (b) a variable that assessed the average frequency with which the abuse occurred (e.g., 1 (*only once or twice ever*); 2 (*a few times a year*); 3 (*1 to 2 times per month*); 4 (*1 to 2 times per week*); 5 (*3 to 5 times per week*); 6 (*almost every day*); 7 (*more than once a day*)).² Alpha reliabilities ranged from .757 to .889 for the child abuse variables; .743 to .849 for IPV; and .673 to .810 for NIPV.

Substance use. Because even a single episode of drug use can have serious adverse implications for women on probation and parole, a dichotomous variable (yes = 1; no = 0) assessed self-reported use of any of the following illicit substances in the past 12 months: marijuana, cocaine, crack, heroin, opiates other than heroin, hallucinogens, sedatives/tranquilizers/barbiturates, methamphetamine, club drugs, and prescription drugs ("... that were not prescribed to you, in excess of what was prescribed for you, and/or for recreational purposes."). In addition, we were also interested in assessing broader patterns of women's substance use, inclusive of both drugs and alcohol, over time. For this reason, six dichotomous variables (yes = 1; no = 0) assessed lifetime engagement in a year or more of regular substance use (defined as an average of three times per week) for alcohol to intoxication, marijuana, crack/cocaine, opiates, and/or sedatives.

Informal social support and formal service use. Informal social support was measured by four items from the Medical Outcomes Study social support survey (Higgins, Golder, Hall, & Logan, 2012; Sherbourne & Stewart, 1991). Respondents were asked about the availability of various types of social support when needed (i.e., "to help with daily chores if you were sick"; "to turn to for suggestions about how to deal with a personal problem"; "to do something enjoyable with"; and "to love and make you feel wanted"). The sum of the four items was used to create an overall index of informal social support (range 0–16; higher scores reflect greater levels of social support; alpha reliability: .89).

Three variables were used to assess formal service utilization over the past 12 months: a dichotomous variable (yes = 1; no = 0) indicating whether a woman reported engaging in drug or alcohol treatment; a variable reflecting the number of domestic violence (DV)-related services received (emergency protection order, calling a hotline, seeking shelter, counseling focused on DV;

¹The PDS assesses Criteria A–F of the *DSM-IV* PTSD diagnosis; a categorical diagnosis of PTSD can be made using the PDS when a woman meets these criteria. Stated another way, the woman's responses to the PDS meet the diagnostic criteria for PTSD when she reports: "the traumatic event involves either injury or life threat; [she] felt helpless or terrified during the event, endorsement (rating of 1 or higher) of at least one reexperiencing symptom, three avoidance symptoms, and two arousal symptoms; duration of at least 1 month; and impairment in at least one area of functioning" (U.S. Department of Veterans Affairs, 2014).

²A total of 15 items assessed the various subtypes of childhood abuse (psychological, eight questions; physical, four questions; sexual, three questions). Correspondingly, eight items assessed psychological IPV, five items assessed physical IPV/NIPV, and three items assessed sexual IPV/NIPV.

0–4 range); and a dichotomous variable (yes = 1; no = 0) indicating whether the participant received any services related to psychological or emotional problems.

Perceived life stress. Perceived life stress was measured by the summary of a 32-item checklist of negative events that may have occurred during the past 12 months (Turner, Wheaton, & Lloyd, 1995). Participants were asked to report whether any of the events had happened to them or to close others (i.e., partner or spouse, children). Examples of possible events included: “a serious illness” and “lost a home due to fire, flood, or other disaster.” Alpha reliability for this sample was .83; observed range: 0–27.

Resource loss. Loss of material resources was assessed using 22 items from the Conservation of Resources Evaluation which examines the extent of material loss over the last 12 months in areas such as food, clothing, money for transportation and children’s essentials (Hobfoll & Lilly, 1993; Hobfoll, Johnson, Ennis, & Jackson, 2003). Loss is rated on a 7-point scale 0 (*no loss*) to 6 (*a great deal of loss*). Internal reliability was .93; observed range: 0 to 132.

Results

Sociodemographic Characteristics and Correctional Status

Women were on average 37 years old (*SD*: 10.23); 41.9% were African American, slightly more than half were White (50.5%), and the remainder fell within the Other racial or ethnic category (7.6%). The majority of participants reported being single (44.6%), 16.7% reported being married or cohabiting with someone of the opposite gender, and 38.7% reported being separated, divorced or widowed. Slightly more than 27% reported less than a GED or high school diploma, 36% reported a GED or high school diploma, and about 32% reported some college or more. Approximately 29% of the women worked part or full time; the remaining 71% reported not working for a variety of reasons. Thirty-four percent of the women reported they were homeless.

The majority of women in the study were on probation (75.6%), while 22.7% were on parole, and a small percentage (1.7%) reported being on both probation and parole. As a group, participants had spent approximately 47 days in a controlled environment in the past 12 months. (For a detailed description of the sample characteristics, see Golder et al., 2014.)

LCA

Models with one to five classes were analyzed (see Table 1). Distal factors (i.e., external variables) were not included in the estimation of the latent class models as this was an exploratory study. Although the smallest BIC value was observed for the four-class model, the BLRT for the four-class model, while statistically significant ($p \leq .001$), failed to replicate four out of five bootstrap draws, suggesting this model was not stable. In contrast, the BLRT was both statistically significant and stable in the three-class model and had excellent classification quality, correctly classifying individuals into their respective Groups 91% of the

Table 1. Statistics for Latent Class Models, One to Four Classes: BIC; ABIC; LL; and Entropy

Model	Description	BIC	Adjusted BIC	LL	Entropy
1	One-class	10218.375	10161.259	–5055.175	—
2	Two-class	7823.845	7734.998	–3827.903	.971
3	Three-class	7282.964	7162.385	–3527.455	.912
4	Four-class	6862.851	6710.541	–3287.391	.931
5	Five-class	6794.589	6610.548	–3276.339	.910

Note. BIC = Bayesian information criteria; ABIC = adjusted Bayesian information criteria; LL = log likelihood value.

time (entropy = .91). Both the three- and four-class models were distinguished by increasing levels of general psychological distress across each of the nine indicators for the identified subgroups; the first class in each model experienced the least psychological distress and the last class experienced the highest level. However, in the four-class model, there were relatively few statistically significant differences on the external variables between Classes 2 and 3 and Classes 3 and 4. Thus, based on the convergence of statistical evidence and the substantive interpretation of the models, the three-class solution was supported (Muthén, 2003).

Class 1, identified as the Low Psychological Distress (Low Distress) group, accounted for 39.8% of the sample. Women in this group experienced relatively low levels of psychological distress compared to women in the other two subgroups. The next group (Class 2), identified as the Moderate Psychological Distress (Moderate Distress) group, comprised 34.9% of the sample. Finally, the third class, included the remaining 25.2% of the participants; this group reported the highest levels of psychological distress and was identified as the High Psychological Distress (High Distress) group (Table 2; Figure 1).

External Variables and Between-Group Comparisons

Overall, findings for the between-groups comparisons on the external variables mirrored those for psychological distress such that increasing levels of risk or distress were observed across each of the three groups (see Table 3). Homelessness was the only sociodemographic indicator to evidence a significant difference in the between-groups analysis. Among women in the High Distress group, 48.8% reported being homeless, while slightly more than 35% of the Moderate Distress group and 24.3% of Low Distress group reported being homeless.

The Low, Moderate and High Distress groups differed significantly from one another on all the indicators of posttraumatic stress. Women in the Low Distress group experienced the lowest level of PTSD symptoms, while women in the High Distress group experienced the most extreme levels of posttraumatic stress symptoms. Approximately 24% of women in the Low Distress group met the diagnostic criteria for PTSD, while the number of women in the Moderate and High Distress groups with PTSD was more than 2 and 3 times higher (58.2% and 76.7% for the Moderate Distress and High Distress groups, respectively).

In terms of victimization, the Moderate and High Distress groups were generally statistically similar; both groups of women experi-

Table 2. Means and Standard Deviations (SD) and Standard Errors (SE) for the Sample and Identified Classes on the Latent Class Indicators

	Sample ¹ (N = 404)		Class 1: Low distress group (n = 161)		Class 2: Moderate distress group (n = 141)		Class 3: High distress group (n = 91)	
	Mean	SD	Mean	SE	Mean	SE	Mean	SE
General psychological distress								
Somatization	1.03	.89	0.33	0.03	1.02	0.08	2.11	0.12
Obsessive-compulsive	1.43	1.03	0.35	0.02	1.50	0.10	2.71	0.11
Interpersonal sensitivity	1.31	1.09	0.36	0.04	1.31	0.15	2.76	0.10
Depression	1.25	1.04	0.35	0.04	1.36	0.17	2.53	0.08
Anxiety	1.18	.99	0.25	0.02	1.23	0.10	2.48	0.12
Hostility	.94	.87	0.31	0.02	0.91	0.09	2.00	0.10
Phobic anxiety	.91	1.00	0.41	0.05	0.82	0.08	2.15	0.16
Paranoid ideation	1.31	.95	0.34	0.03	1.44	0.11	2.43	0.09
Psychoticism	1.17	.96	0.27	0.02	1.22	0.12	2.42	0.10

¹ All analyses for the sample conducted with SPSS; all analyses for the latent classes conducted with Mplus. Mplus data are raw data.

enced significantly more recent and lifetime victimization than women in the Low Distress group, with the exception of ever experiencing psychological IPV, where there were no statistically significant differences among the three groups. Women in the High Distress group experienced a higher frequency of childhood psychological victimization and more frequent psychological and physical IPV in adulthood than women in the Moderate and Low Distress groups. In addition, a significantly higher percentage of women in the High Distress group reported experiencing sexual NIPV (76.4%) than

women in either of the other two subgroups (46.0% and 63.2%, respectively, for the Low and Moderate Distress groups).

Statistically significant differences among the subgroups were identified for drug use in the past 12 months and regular use of alcohol to intoxication, opiates, and sedatives. Generally, the data trend suggested increasing levels of substance use in each group consistent with the level of psychological distress. However, the pattern of statistical significance was a bit more complex. On every substance use indicator for which there was statistical significance, women in the Low Distress group differed from women in the High Distress group, although not necessarily from women in the Moderate Distress group. Women in the High Distress group were distinguished by the highest rates of regular use of alcohol to intoxication (69.6% compared with 49.2% and 53.2%, respectively, for the Moderate and Low Distress groups) and opiates (50.2% compared to 36.0% and 27.8%, respectively, for the Moderate and Low Distress groups).

The High Distress group evidenced the least amount of informal social support (8.38 compared with 11.32 and 10.37, respectively, for the Low and Moderate Distress groups). In contrast, both the Moderate and High Distress groups evidenced statistically similar and higher levels of domestic violence service utilization. The Moderate and High Distress groups were significantly more likely to have utilized psychological services than the Low Distress group (49.0% and 60.0% for the Moderate and High Distress groups, respectively, compared to 30.1% for the Low Distress group).

Finally, in the areas of resource loss and perceived stress, the pattern of increasing risk or distress from the Low to High Distress groups was again evident with statistically significant differences between each of the groups.

Discussion

This is the first known study to identify subgroups of victimized women on probation and parole based on indicators of general psychological distress. Indicators of general psychological distress were used to identify distinct subgroups of women because a growing body of research suggests that intersections between mental health, substance use, victimization, and trauma are related to women's involvement in the criminal justice system (Bloom et al., 2003; Lynch et al., 2013; Reisig et al., 2006; Salisbury, & Van Voorhis, 2009). As such,

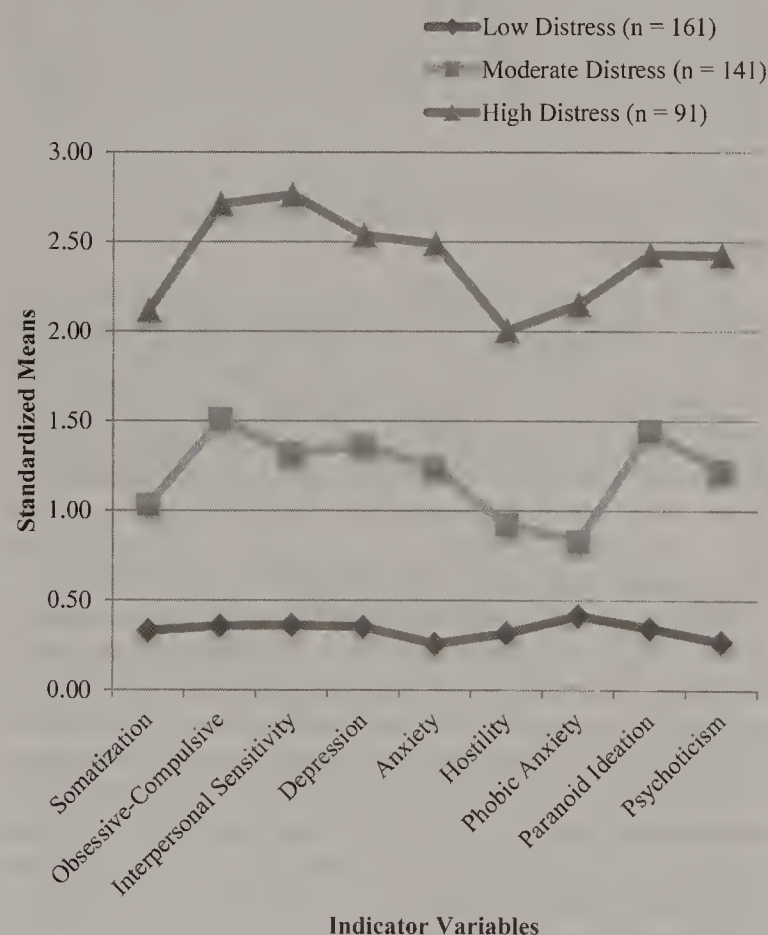


Figure 1. Standardized mean scores of three subgroups of victimized women on probation and parole across nine latent class indicator variables.

Table 3. Sample Mean/Percentages and Between-Group Differences: PTSD, Cumulative Victimization, Substance Use and Other Psychosocial Factor¹

	Sample		Low distress group		Moderate distress group		High distress group		
	Mean/%	SD	Mean/%	SE	Mean/%	SE	Mean/%	SE	Chi-Square
PTSD									
Criterion A	85.43%	.35	76.1% ^A	0.03	91.2% ^B	0.02	92.2% ^B	0.02	16.543**
Symptom severity	18.16	14.07	10.02 ^A	0.85	19.50 ^B	1.09	28.83 ^C	1.37	152.188**
Count of life domains	3.26	2.82	1.47 ^A	0.17	3.80 ^B	0.22	5.31 ^C	0.24	184.891**
PTSD	48.88%	.50	23.5% ^A	0.03	58.2% ^B	0.04	76.1% ^C	0.04	101.673**
Childhood victimization									
Psychological (ever)	75.25%	.43	68.3% ^A	0.03	76.2% ^{AB}	0.03	84.9% ^B	0.03	9.994**
Psychological (frequency)	1.38	1.46	0.97 ^A	0.10	1.342 ^B	0.12	2.07 ^C	0.16	32.833**
Physical (ever)	64.11%	0.48	57.4% ^A	0.04	61.0% ^A	0.04	78.9% ^B	0.04	14.282**
Physical (frequency)	1.17	1.43	0.84 ^A	0.09	1.075 ^A	0.12	1.82 ^B	0.16	25.189**
Sexual (ever)	38.86%	.48	33.2% ^A	0.038	37.3% ^{AB}	0.04	50.0% ^B	0.05	6.760*
Sexual (frequency)	.79	1.34	0.63 ^A	0.09	0.743 ^{AB}	0.11	1.11 ^B	0.16	6.310*
IPV									
Psychological (ever)	95.54%	.20	93.5%	0.02	96.3%	0.01	97.8%	0.01	2.876
Psychological (frequency)	1.06	1.47	0.56 ^A	0.09	1.11 ^B	0.13	1.77 ^C	0.18	38.253**
Physical (ever)	89.60%	.30	84.4% ^A	0.02	91.8% ^B	0.02	94.8% ^B	0.02	8.260*
Physical (frequency)	.29	.65	0.14 ^A	0.03	0.29 ^B	0.05	0.54 ^C	0.10	16.654**
Sexual (ever)	53.22%	.49	39.5 ^A	0.04	57.7% ^B	0.04	68.7% ^B	0.04	24.809**
Sexual (frequency)	.13	.50	0.04 ^A	0.02	0.23 ^B	0.065	0.163 ^B	0.05	11.736*
Non-intimate-partner violence									
Physical (ever)	56.68%	.49	44.1% ^A	0.04	61.4% ^B	0.04	70.1% ^B	0.04	20.082**
Physical (frequency)	.07	.31	0.01 ^A	0.01	0.10 ^B	0.03	0.13 ^B	0.04	13.589**
Sexual (ever)	59.65%	.49	46.0% ^A	0.04	63.2% ^B	0.04	76.4% ^C	0.04	27.059**
Sexual (frequency)	.08	.42	0.01 ^A	0.00	0.11 ^B	0.03	0.16 ^B	0.07	10.731**
Substance use									
Use past 12 months	46.04%	.49	38.1% ^A	0.03	48.0% ^{AB}	0.04	55.8% ^B	0.05	8.258*
Regular alcohol use	55.79%	.49	53.2% ^A	0.04	49.2% ^A	0.04	69.6% ^B	0.04	9.458**
Regular marijuana use	73.23%	.44	73.8%	0.03	72.4%	0.04	73.4%	0.04	0.063
Regular crack/cocaine use	57.77%	.49	54.8%	0.04	57.7%	0.04	62.7%	0.05	1.472
Regular opiate use	36.22%	.48	27.8% ^A	0.03	36.0% ^A	0.04	50.2% ^B	0.05	12.597**
Regular sedative use	31.79%	.46	22.4% ^A	0.03	34.7% ^B	0.04	43.1% ^B	0.05	13.013**
Other psychosocial factors									
Informal social support	10.24	4.45	11.32 ^A	0.32	10.37 ^B	0.35	8.38 ^C	0.49	24.524**
Drug treatment	40.35%	.49	34.3%	0.03	43.4%	0.04	45.7%	0.05	4.372
DV services	1.4950	1.29	1.23 ^A	0.09	1.54 ^B	0.11	1.84 ^B	0.13	14.256**
Psychological services	44.28%	.49	30.1% ^A	0.03	49.0% ^B	0.04	60.0% ^B	0.04	26.583**
Resource loss	57.35	34.55	46.26 ^A	2.79	56.08 ^B	2.68	76.65 ^C	3.08	51.866**
Perceived stress	7.5025	5.04	5.55 ^A	0.34	7.71 ^B	0.43	10.29 ^C	0.51	61.175**
Homeless	34.24%	.47	24.3% ^A	0.03	35.2% ^B	0.04	48.8% ^C	0.05	16.616**

¹ The same superscripts denote that means between the two groups for each variable are statistically equivalent (i.e., not significantly different).

* $p \leq .01$. ** $p \leq .05$.

there is a critical need to understand heterogeneity in women's experiences to inform practice and policy in nuanced and evidence-based ways. Examination of the group means across the latent class indicators, as well as the indicators of PTSD, indicate that the women in this sample, as a group, appear to experience a great deal of psychological distress. Raw scores on all nine of the symptom dimensions for the entire sample far exceed clinical thresholds indicative of a mental health problem (Golder & Logan, 2010; Potter & Jenson, 2003). Comparisons of these data to published findings among incarcerated and drug-involved women indicate that raw scores for the present sample were generally higher than those previously observed (Islam-Zwart, Vik, & Rawlins, 2007; Schiff, El-Bassel, Engstrom, & Gilbert, 2002; Vik, 2007). However, interpretation of these findings changes

substantially when examining the subgroups. In fact, almost 40% of the women (i.e., the Low Distress group) in this study had raw scores on the latent class indicators that were well below published cut-offs indicative of mental health problems. Conversely, among women in the High Distress group, raw scores on all of the latent class indicators were equivalent to or greater than t -scores of 70, placing them in at least the 98th percentile or higher in respect to psychological distress among women community samples (Derogatis, 1993). Thus, the present research uncovered important heterogeneity in psychological distress using a highly reliable and easily accessible measure. As such, findings can be used to enhance mental health screening within probation and parole departments and other care systems that serve women involved in the justice system.

With regard to alcohol and drug use, women in the Moderate and High Distress groups evidenced a number of higher risk behaviors. The women in the High Distress group had the highest prevalence of drug use in the last 12 months (55.8%). Lifetime history of regular drug and alcohol use tended to be higher in the Moderate and High Distress groups than in the Low Distress groups. Additionally, half of the women in the High Distress group reported a lifetime history of regular use of opiates, and 43.1% regularly used sedatives, tranquilizers or barbiturates at some point in their lives. The regular use of these drugs, especially in tandem, has the potential to place women in the High Distress group at increased risk of drug overdose (Hall et al., 2008). Prior research suggests that substance use may be motivated by self-treatment of psychological and physical distress (Boyd, McCabe, & Teter, 2006; Gilbert et al., 2000; McCabe, Boyd, & Teter, 2009) as hypothesized in the self-medication model (Chilcoat & Breslau, 1998a, 1998b; Hien et al., 2010). This model may explain the current findings; however, the inability to confirm the temporal ordering of psychological distress and substance use leaves room for alternative explanations. Notwithstanding, the current findings suggest that particularly among women experiencing a high level of distress there is a need for integrated treatment approaches that can address mental health and substance use needs, as well as trauma and other co-occurring psychosocial concerns simultaneously (for a discussion see Engstrom, El-Bassel, & Gilbert, 2012).

Prior research indicates that few individuals involved in community supervision receive needed substance use treatment or ancillary services, and that when it is received, it is of low intensity (Taxman, Perdoni, & Harrison, 2007). Findings from the present study indicate that while most of the women had not been in drug treatment in the last year (i.e., only 34%, 43%, and 46% of the Low, Moderate, and High Distress groups, respectively, engaged in treatment), women experiencing more psychological distress and victimization were higher users of psychological and domestic violence services during this time period. Notwithstanding these comparably higher levels of utilization of specific services, there remained a considerable portion of women in the Moderate and High Distress groups who did not access services despite complex needs. For example, 40% and 51% of women in the Moderate and High Distress groups, respectively, reported not receiving psychological services in the past 12 months. This finding suggests the importance of policies and practices that expand outreach, assessment, referral and linkage to services that address psychological distress and concomitant concerns among victimized women on probation and parole.

As with substance use, there was an increasing pattern of cumulative victimization across the three groups. Prior research has found that childhood victimization is associated with increased psychological distress in adulthood across a variety of populations, including women in the justice system (Edwards, Holden, Felitti, & Anda, 2003; Kennedy, Tripodi, & Pettus-Davis, 2013; Varese et al., 2012). Specifically, a dose-response model has been used to describe this relationship such that as the number of different types of abuse experienced increases, subsequent psychological distress also increases (Edwards et al., 2003). For example, in a random sample of 159 incarcerated women, individuals who experienced childhood physical and sexual abuse were 2.4 times more likely to experience current psychological distress (e.g., psychosis) than women who experienced either childhood physical or sexual abuse alone (Kennedy et al., 2013). Although the present research did not specifically test the

dose-response model, our findings underscore this association. The dose-response model is also evident when examining the increased prevalence of PTSD across the three groups. Among the women who experienced the lowest levels of childhood victimization, the Low Distress group, less than a quarter met the diagnostic criteria for PTSD; in contrast, rising levels of childhood victimization among the Moderate and High Distress subgroups were associated with increased levels of PTSD (58.2% and 76.1%, respectively).

In regard to adult violence, the subgroups were distinguished by differences in the frequency of psychological and physical IPV and the experience of sexual NIPV, with the High Distress group reporting the greatest frequency of adult victimization. Prior research has demonstrated that women who experience IPV are disproportionately affected by psychological distress compared to women who do not experience IPV (Dutton et al., 2006; Golder et al., 2012; Golding, 1999; Jones, Hughes, & Unterstaller, 2001; Schiff et al., 2002). More specifically, the current findings are consistent with research that shows that increased severity and frequency of physical and psychological IPV, in particular, are associated with greater psychological distress, generally, and PTSD, specifically (Dutton et al., 2006). Finally, the pattern of cumulative victimization across the three subgroups should also be understood in the context of evidence that childhood victimization is associated with increased likelihood of experiencing IPV in adulthood (Bensley, Van Eenwyk, & Wynkoop Simmons, 2003; Desai, Arias, Thompson, & Basile, 2002; Engstrom, El-Bassel, Go, & Gilbert, 2008; Whitfield, Anda, Dube, & Felitti, 2003).

Taken together the results of this study suggest that there are subgroups of victimized women on probation and parole who experience especially complex combinations of needs that require multifaceted assessment and intervention strategies. Of relevance is research that finds that integrated mental health and substance use treatment is associated with lower costs and better outcomes (e.g., reduced substance use, improved psychiatric symptoms and functioning, reduced reincarceration; SAMHSA, 2014). Similarly, there is increasing recognition that the experiences of victimization and trauma play significant roles in women's involvement in the criminal justice system. As such, service delivery for this population should not only be integrated, but trauma informed (for further discussion of trauma-informed and trauma-specific care see The SAMHSA National GAINS Center, 2011). For example, The Boston Consortium Model: Trauma-Informed Substance Abuse Treatment for Women (Amaro et al., 2005) is a trauma-informed, integrated approach to address co-occurring issues related to substance use, mental health, and trauma. Its comprehensive model has been integrated into substance abuse treatment programs serving clients experiencing multiple stressors, including high rates of court-ordered participation, and could be adapted for use with women on probation and parole (Amaro et al., 2007).³

³The Boston Consortium Model is listed on Substance Abuse & Mental Health Services Administration's (SAMHSA) National Registry of Evidence-Based Programs and Practices, which is a searchable online registry of substance abuse and mental health interventions (<http://www.samhsa.gov/nrepp>). In addition, The SAMHSA National GAINS Center (2011) has published an overview of trauma-specific interventions for justice-involved individuals.

There are several limitations to this research. This study focused exclusively on women on probation and parole with experiences of victimization and was restricted to a single urban county in the southern United States. Given the prevalence of victimization among justice-involved women, the most relevant questions are not limited to identifying differences between victimized and nonvictimized women. Rather, research that helps highlight clinically meaningful within-group differences is necessary to inform targeted interventions for this population. Participants in this study were not randomly selected and these results are not generalizable to all women on probation and parole. Women who responded to the recruitment strategies and were subsequently enrolled as participants may differ in substantively meaningful ways from women who did not participate. Women who reported only having sex with other women were excluded from participation. The dynamics of intimate partner violence between same gender partners may be similar to and/or distinct from violence between opposite gender partners among women on probation and parole with histories of victimization; however, this question was outside the focus of the present study. Further attention to this issue is an important priority for future research. The present study is cross-sectional; inferences regarding the temporal sequencing of variables should be viewed cautiously. Finally, this research relied on self-reports of sensitive information that may have yielded underreports of some experiences and behaviors. However, the use of ACASI technology minimizes this risk; ACASI technology can enhance reporting of potentially sensitive information by increasing privacy (e.g., only the respondent can see and hear the questions being asked and the corresponding responses), particularly as compared to interviewer-administered questionnaires (Metzger et al., 2000; Schroder, Carey, & Venable, 2003; Wolff & Shi, 2012).

This study advances knowledge regarding the heterogeneity of clusters of challenges experienced by victimized women on probation and parole and highlights intersections between psychological distress, substance use, victimization, and other psychosocial factors. This research identified distinct subgroups of women who experience particularly high levels of psychological distress and multiple, co-occurring concerns, and who, as a consequence, may be at increased risk for negative outcomes. Identifying higher risk women and providing integrated, trauma-informed services to address their complex needs and challenges may be a pivotal step toward improved mental health and reduced substance use, revictimization, and criminal justice involvement among women on probation and parole with histories of victimization (Engstrom et al., 2008; Johnson et al., 2011; The SAMHSA National GAINS Center, 2011).

Keywords: women; probation; parole; psychological distress; BSI; victimization

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BRIEF REPORT

Regional and National Differences in Stressful Life Events: The Role of Cultural Factors, Economic Development, and Gender

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The study analyzed differences in the risk of experiencing stressful life events (SLE) according to cultural factors, the level of economic development of the region inhabited, and gender. Information was gathered on the number and nature of SLE experienced by a sample of 604 undergraduates from 3 regions with very different levels of economic development: Madrid (Spain), León (Nicaragua), and Bilwi (Nicaragua). The results indicated a greater risk of experiencing SLE among undergraduates from Nicaragua, but few differences attributed to the undergraduates' gender or the level of economic development in the region they inhabit within the same country.

Stressful life events (SLEs) are experiences that play a key role in one's life and that frequently cause significant changes for the person involved. There are significant differences in the number of SLEs experienced by populations with similar demographic characteristics depending on the level of economic development in their countries: The inhabitants of less developed countries appear to be more prone to experiencing SLEs (Vázquez, Panadero, & Rincón, 2007). According to Hatch and Dohrenwend (2007), there have been few studies of the distribution of SLEs by gender, especially in contexts of low levels of economic and social development. There is some consensus that men and women experience different types of SLEs. Whereas women tend to experience SLEs of a more interpersonal nature, rape and sexual assault, men experience SLEs that are more related to legal and employment issues, as well as injury traumas, serious accidents, illness, and hospitalization (Hatch & Dohrenwend, 2007).

Few studies in the literature analyze whether the differences in experiencing SLEs not only occur across countries with different levels of economic and social development, but also across regions

with similar cultural references but different levels of development in the same country. Such studies would permit analysis of the role of the level of economic development and cultural factors in the occurrence of these stressful life events. Nor have there been any studies of the differences in experiencing SLEs according to the gender of the individual in combination with the level of his or her country's economic and social development.

To provide some such analysis, this study was conducted with undergraduates in two countries with different levels of economic and social development: Spain (ranked 23 in the Human Development Index, HDI) and Nicaragua (ranked 129 in the HDI; UNDP, 2011). All the Spanish participants were students in Madrid, and the Nicaraguan participants studied in León (Departamento de León) and Bilwi (Región Autónoma del Atlántico Norte, RAAN), cities in regions with different economic and social levels of development. The RAAN has the lowest levels of economic development in Nicaragua and, according to the United Nations Development Program (UNDP), a low HDI as opposed to the Departamento de León's medium level HDI.

Method

Six-hundred and four undergraduates took part in the study, 156 men (25.8%) and 448 women (74.2%), with a mean age of 21.94 years old ($SD = 4.46$). Of these, 336 were studying in Madrid (Spain; 65.6% women and 34.4% men; M age = 21.63; $SD = 4.08$), 167 were studying in León (Nicaragua; 86.7% women and 13.3% men; M age = 20.92; $SD = 2.46$) and 101 were studying in

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Bilwi (Nicaragua; 61.3% women and 38.7% men; M age = 21.96; SD = 3.48).

All the participants were undergraduates from one of the following universities: Complutense University of Madrid (Spain), University of Alcalá (Spain), National Autonomous University of Nicaragua in León (Nicaragua), or University of the Autonomous Regions of the Caribbean Coast Nicaragua (URACCAN) in Bilwi (Nicaragua).

Access to the students in their randomly chosen classrooms was achieved with the collaboration of the centers' faculty and managerial staff. After being told that participation was completely voluntary, students were informed that the questionnaires would be completed anonymously and that the data collected would be used exclusively for research purposes. The participants were asked to give their informed consent. The questionnaires were completed by groups of students simultaneously.

To collect information on the SLEs suffered by the interviewees, a list of 20 selected vital events was used (see Tables 1, 2, and 3). This list was created after reviewing the SLEs considered in other studies conducted on different Spanish-speaking populations (Vázquez et al., 2007). Participants had to respond if they had experienced each of the SLEs or not (dichotomizing answer).

Differences in SLEs experienced across different regions and according to gender were identified. For nominal-level data, the statistical significance of the differences was tested using chi-square analyses. For interval-level data, the differences were tested using t tests. Levene tests for variance equality were computed prior to calculating the t tests. If the variances in the two groups were not the same, the separate variance formula was used to calculate the t test. If the variances were the same, the basic pooled variance formula was used. The risk of each SLE for individuals

from the different places was compared. In univariate analyses, the odds ratios were computed with 95% confidence intervals using standard methods.

Results

The results showed differences in terms of the number of SLEs experienced by undergraduates in Madrid, León, and Bilwi ($F_2 = 116.68$, $p < .001$). The mean number of SLEs experienced by students from Madrid (M SLEs = 0.92; SD = 1.42) was significantly lower, $t = 7.68$, $p < .001$, than the amount experienced by students in Bilwi (M SLEs = 3.18; SD = 2.26) and in León (M SLEs = 3.44; SD = 2.27), $t = 7.69$, $p < .001$. However, there were no statistically significant differences in the mean number of SLEs experienced by the participants in Bilwi and León.

There were significant differences between undergraduates from Spain and Nicaragua with respect to their experience of several specific SLEs (Table 1 and Table 2).

There were relatively few statistically significant differences between Nicaraguan undergraduates from León and Bilwi with respect to their experience of certain SLEs (see Table 3).

No statistically significant differences were found regarding the mean number of SLEs experienced by Spanish men and women (M SLEs = 1.04; SD = 1.63, and M SLEs = 0.91; SD = 1.36, respectively), $t = 0.75$, $p < .450$, or by Nicaraguan men and women (M SLEs = 3.19; SD = 2.10, and M SLEs = 3.65; SD = 2.41, respectively), $t = 1.40$, $p < .164$. Statistically significant differences by gender were only observed among undergraduates in Spain for the risk of "excessive consumption of drugs or alcohol" (17.2% men and 7.9% women; $\chi^2 = 6.28$, $p < .05$). The odds ratios indicate that the risk of "excessive composition of drugs or alcohol" is higher among men than among women in

Table 1. Frequency (%) of Stressful Life Events Among Spanish (Madrid) and Nicaraguan (Bilwi) Participants

Stressful life events	Frequency		χ^2	Odds ratio	95% CI
	Madrid (Spain)	Bilwi (Nicaragua)			
Parental drug/alcohol abuse (before 18 years)	3.9	23.6	37.05***	7.65	3.65–16.02
Parental mental and physical health problems (before 18 years)	13.4	15.6	.30		
Physical/sexual abuse (before 18 years)	3.0	10.8	9.91**	3.93	1.58–9.75
Ran away from home (before 18 years)	3.0	8.5	5.61*	3.03	1.16–7.92
Parental divorce/separation (before 18 years)	10.2	45.3	61.82***	7.30	4.26–12.49
Raised by people other than parents (before 18 years)	3.9	13.5	12.22***	3.87	1.73–8.66
Father's death	3.3	16.1	21.05***	5.66	2.50–12.81
Mother's death	1.8	11.7	19.02***	7.30	2.62–20.28
Death of spouse or partner	.0	5.4	18.28***		
Illness or injury	7.4	29.8	33.94***	5.28	2.89–9.63
Divorce/separation	.0	14.9	51.73***		
Significant economic problems	4.8	48.9	116.1***	19.17	10.06–36.52
Significant unemployment problems	3.3	37.0	86.80***	17.27	8.28–36.01
Excessive consumption of drugs or alcohol	10.7	7.4	.87		
Mental health problems	1.2	8.6	14.72***	7.81	2.30–26.56
Loss of home due to eviction, demolition, or other causes	.9	20.8	58.90***	29.21	8.46–100.82
Change of residence because of work	16.7	27.4	5.51*	1.88	1.10–3.21
Physical/sexual abuse (after 18 years)	1.5	9.7	15.35***	7.05	2.30–21.59
Spousal/partner abuse	1.2	5.4	6.21*	4.72	1.24–17.93
Suicide attempt	.9	11.7	27.25***	14.71	4.01–53.93

* $p \leq .05$. ** $p \leq .01$. *** $p \leq .001$.

Table 2. Frequency (%) of Stressful Life Events Among Spanish (Madrid) and Nicaraguan (León) Participants

Stressful life events	Frequency		χ^2	Odds ratio	95% CI
	Madrid (Spain)	León (Nicaragua)			
Parental drug/alcohol abuse (before 18 years)	3.9	33.9	83.97***	12.72	[6.70, 24.16]
Parental mental and physical health problems (before 18 years)	13.4	25.9	11.80***	2.26	[1.41, 3.61]
Physical/sexual abuse (before 18 years)	3.0	17.0	30.91***	6.66	[3.15, 14.09]
Ran away from home (before 18 years)	3.0	5.5	1.86	1.88	[.75, 4.72]
Parental divorce/separation (before 18 years)	10.2	50.0	97.12***	8.82	[5.52, 14.11]
Raised by people other than parents (before 18 years)	3.9	14.0	16.84***	4.03	[1.9, 8.180]
Father's death	3.3	11.0	11.90***	3.63	[1.67, 7.88]
Mother's death	1.8	1.8	.00		
Death of spouse or partner	.0	1.9	6.50*		
Illness or injury	7.4	29.7	43.54***	5.25	[3.10, 8.90]
Divorce/separation	.0	2.0	6.85**		
Significant economic problems	4.8	69.7	241.63***	46.00	[25.20, 83.98]
Significant unemployment problems	3.3	19.6	36.77***	7.19	[3.51, 14.74]
Excessive consumption of drugs or alcohol	10.7	6.7	2.08		
Mental health problems	1.2	2.4	1.09		
Loss of home due to eviction, demolition, or other causes	.9	5.5	10.02**	6.49	[1.73, 24.30]
Change of residence because of work	16.7	28.4	9.23**	1.98	[1.27, 3.10]
Physical/sexual abuse (after 18 years)	1.5	6.7	9.70**	4.76	[1.63, 13.94]
Spousal/partner abuse	1.2	6.4	10.50***	5.68	[1.75, 18.42]
Suicide attempt	.9	10.9	27.64***	13.59	[3.94, 46.85]

* $p \leq .05$. ** $p \leq .01$. *** $p \leq .001$.

Spain (OR = 0.41; 95% CI [0.20, 0.84]). Meanwhile, among undergraduates in Nicaragua, women appear to have experienced "physical/sexual abuse (before 18 years)" to a greater extent than men (6.3% men and 18.6% women, $\chi^2 = .70$, $p < .05$) as well as "spousal/partner abuse" (1.6% men and 10.1% women, $\chi^2 = 4.85$,

$p < .05$.) The odds ratios indicate that the risk of experiencing "physical/sexual abuse (before 18 years)" and "spousal/partner abuse" is significantly higher among women than among men in Nicaragua (OR = 3.42; 95% CI [1.18, 9.91] and OR = 7.10; 95% CI [0.94, 53.51], respectively).

Table 3. Frequency (%) of Stressful Life Events Among Nicaraguan (Bilwi and León) Participants

Stressful life events	Frequency		χ^2	Odds ratio	95% CI
	Bilwi (Nicaragua)	León (Nicaragua)			
Parental drug/alcohol abuse (before 18 years)	23.6	33.9	2.93	1.66	
Parental mental and physical health problems (before 18 years)	15.6	25.9	3.72	1.89	
Physical/sexual abuse (before 18 years)	10.8	17.0	1.83	1.70	
Ran away from home (before 18 years)	8.5	5.5	.91	.62	
Parental divorce/separation (before 18 years)	45.3	50.0	.54	1.21	
Raised by people other than parents (before 18 years)	13.5	14.0	.12	1.04	
Father's death	16.1	11.0	1.41	.64	
Mother's death	11.7	1.8	11.26***	.14	[.38, .52]
Death of spouse or partner	5.4	1.9	2.23	.34	
Illness or injury	29.8	29.7	.00	1.00	
Divorce/separation	14.9	2.0	14.57***	.12	[.03, .42]
Significant economic problems	48.9	69.7	10.97***	2.40	[1.42, 4.05]
Significant unemployment problems	37.0	19.6	9.08**	.42	[.23, .74]
Excessive consumption of drugs or alcohol	7.4	6.7	.50	.89	
Mental health problems	8.6	2.4	5.06	.27	
Loss of home due to eviction, demolition, or other causes	20.8	5.5	14.25***	.22	[.97, .51]
Change of residence because of work	27.4	28.4	.31	1.05	
Physical/sexual abuse (after 18 years)	9.7	6.7	.70	.67	
Spousal/partner abuse	5.4	6.4	.11	1.20	
Suicide attempt	11.7	10.9	.38	.92	

* $p \leq .05$. ** $p \leq .01$. *** $p \leq .001$.

Discussion

The results showed a relationship between the experience of SLEs and the level of economic development of the country where the students lived. The number of SLEs experienced by undergraduates from Nicaragua was almost 4 times higher than that experienced by students from Spain, which increased the risk among the former of suffering from physical and mental health problems (Cropley & Steptoe, 2005; Hackett et al., 2000; Hatch & Dohrenwend, 2007). Likewise, the risk of suicidal behavior among Nicaraguan undergraduates was 14 times higher than among their Spanish counterparts.

The major economic differences between Nicaragua and Spain may help to explain this variation in the risk of experiencing certain SLEs, especially those related to financial issues (the risk of financial problems for Madrid undergraduates was 46 times lower than for students from León, and the risk of unemployment problems for the same students was 17 times lower than for students from Bilwi) and health (the risk of illness or injury for undergraduates in Nicaragua was 5 times greater than for those in Madrid). These differences in the risk of experiencing health problems could be related to issues such as differences in lifestyle, diet, health education, housing quality and amenities, and access to quality health care (Vázquez et al., 2007), all of which are largely related to financial issues.

The results also showed significant differences with respect to experiencing SLEs in the early years of life. The risks of Nicaraguan undergraduates experiencing "parental drug/alcohol abuse," "parental divorce/separation," or being "raised by people other than parents" were approximately 10, 8, and 4 times higher respectively than for Spanish undergraduates. These indicators of family breakdown could be associated with the increased risk among Nicaraguan undergraduates of experiencing "physical/sexual abuse" (approximately 5 times higher than among Spanish students). This issue has been linked with a broad range of psychiatric disorders (Shapiro et al., 2012; Sugaya et al., 2012). Although the different levels of risk of experiencing early SLEs may be indirectly related to the economic environment, they appear to be much more related to cultural variables. In fact, no statistically significant differences were observed between the inhabitants of the two regions in Nicaragua, which have similar cultural characteristics but different levels of economic development.

With respect to the issue of gender violence, the available data suggest the existence of differences between Nicaragua and Spain. Thus, while in Nicaragua 23% of women between 20 and 24 years old have been affected by this kind of violence (Bott, Guedes, Goodwin, & Mendoza, 2012), in Spain, official data speak of 12.3% women (under 30 years old) affected by the same phenomenon (Observatorio de la Violencia de Género, 2011). This study's results are consistent with these data. Although the figures are lower, probably because of the younger age of the participants and other factors related to the composition of the sample (i.e., the educational level of the participants), significant differences were observed between undergraduates from Spain and Nicaragua in terms of risk of "spousal/partner abuse." These experiences of abuse may be related to the differences in the risk of "divorce/separation." Differences in both issues may be mainly caused by cultural

factors: Marriage and cohabitation tended to occur at much younger ages in Nicaragua than in Spain, thus facilitating the divorce and separation at an earlier age, and pregnancies, often unwanted or unplanned, were more common among young Nicaraguan adolescents. Also, differences between Spanish and Nicaraguan cultural conceptions of the roles of men and women in relationships (Vázquez, 2013) may help explain the high risk of experiencing domestic violence among female Nicaraguan undergraduates.

Only minor differences were observed in the risk of experiencing SLEs according to the level of economic development of the region inhabited within the same country, with similar cultural references across regions. This should problematize the relationship between economic development and risk of experiencing SLEs observed when comparing countries with significant cultural differences. In fact, with respect to the risk of experiencing SLEs related to financial issues, the data were not consistent among the participants from León and Bilwi. However, those same participants did show differences regarding their experience of several specific SLEs, with a higher risk among the university students from the region with lowest level of development.

The results showed no differences according to gender in the mean number of SLEs experienced, whether among university students in Spain or among their Nicaraguan counterparts. However, some isolated differences were observed in relation to certain specific SLEs. Male undergraduates from Spain were at greater risk of excessive consumption of alcohol or drugs than Spanish women, a difference that was not observed among students in Nicaragua. Female undergraduates in Nicaragua were at a higher risk than male students in the country of experiencing physical or sexual abuse before the age of 18 years old and of experiencing abuse from their spouse or partner. Spanish undergraduates presented no difference in this respect because this type of stressful event was experienced by only a small percentage of the students interviewed.

It should be noted that this study was subject to some limitations which mainly derived from the use of samples from a very specific sector of the population, namely undergraduates. As a result, the findings can scarcely be generalized. This sector differs in significant ways (culturally, economically, and politically) from the group of young people and, of course, from the overall population. Further limitations stem from the use of self-reported measures, which are subject to different biases. Finally, the study's observational design means that causal relations cannot be determined.

Keywords: stressful life events; economic development; sex

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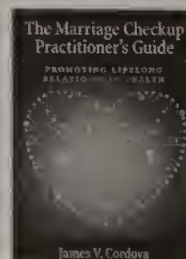
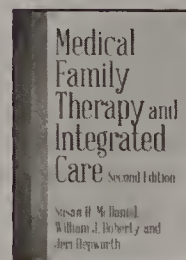
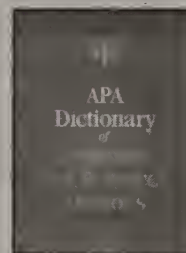
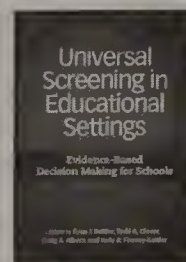
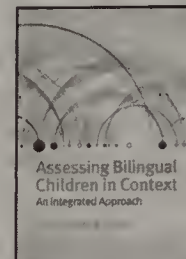
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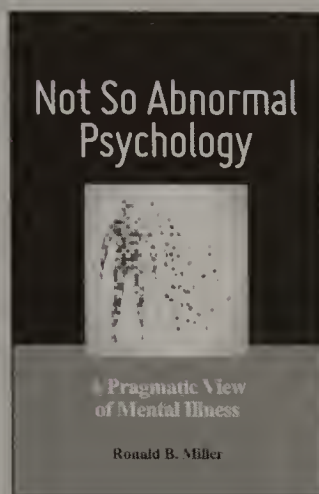




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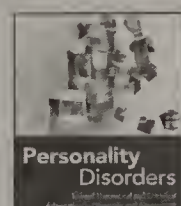
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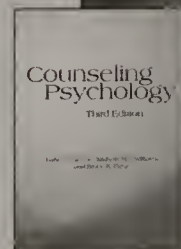
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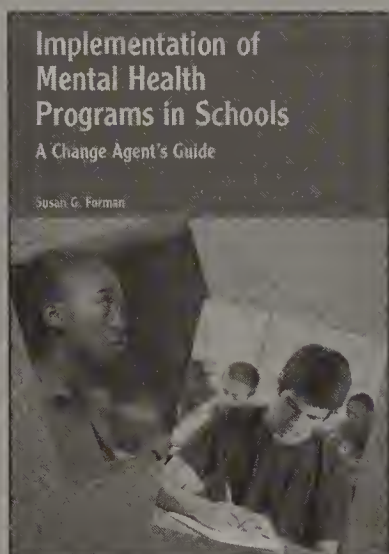
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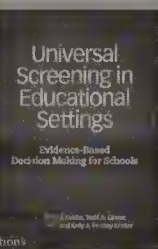
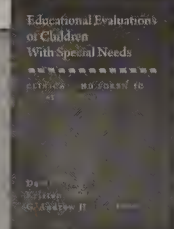
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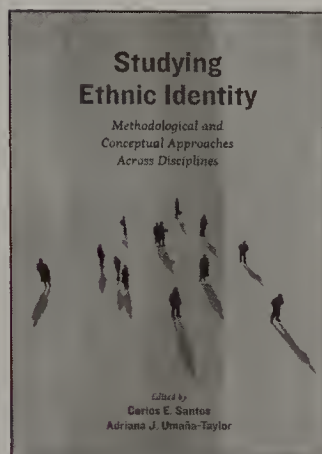
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STUDYING ETHNIC IDENTITY

Methodological and Conceptual Approaches Across Disciplines

Edited by Carlos E. Santos and Adriana J. Umaña-Taylor



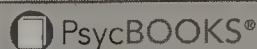
Humans are a fundamentally social species. As individuals, we construct our identity through our affiliation, interaction, and identification with larger groups. And in diverse and multiethnic societies like ours, ethnic identity takes on an especially profound importance. In recent years, social scientists have been increasingly studying the meaning, process, and content of ethnic identity, but these efforts have been piecemeal, and the field as a whole has suffered from a lack of conceptual clarity and methodological rigor.

In this book, editors Carlos Santos and Adriana Umaña-Taylor bring together a diverse group of social and applied scientists from a wide range of fields including educational anthropology, developmental, community and social psychology, and sociology. Together, they investigate the process by which ethnic identity is formed and maintained throughout the lifespan. Authors present qualitative and quantitative approaches to conceptualizing and measuring ethnic identity, including narrative psychology and ethnographic approaches, cognitive schemas and semi-structured interviews, as well as analyses of social networks. Throughout, authors present contextually-rich accounts of ethnic identity that keep the focus where it belongs, on the lived experience of real people. 2015. 272 pages. Hardcover.

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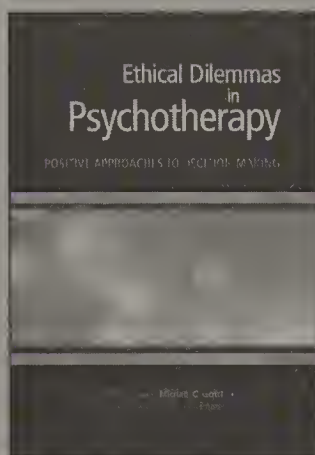
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Positive Approaches to Decision Making

Samuel J. Knapp, Michael C. Gottlieb, and Mitchell M. Handelsman



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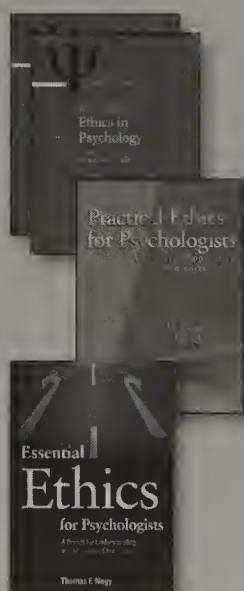
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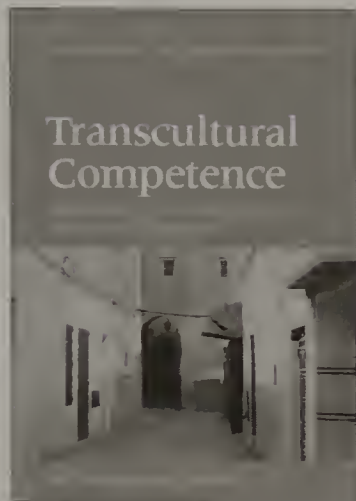
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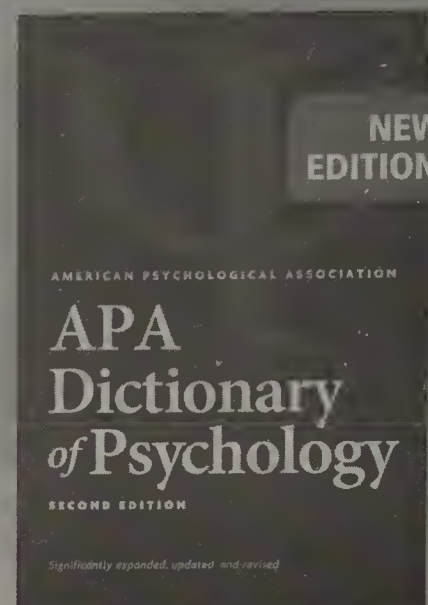
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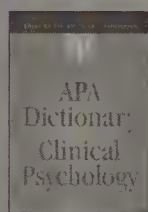
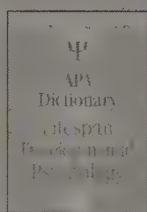
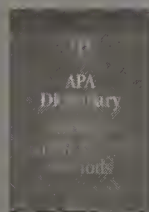
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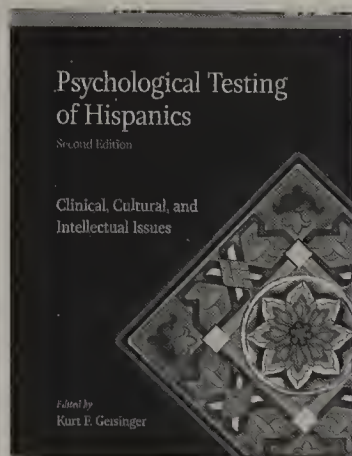
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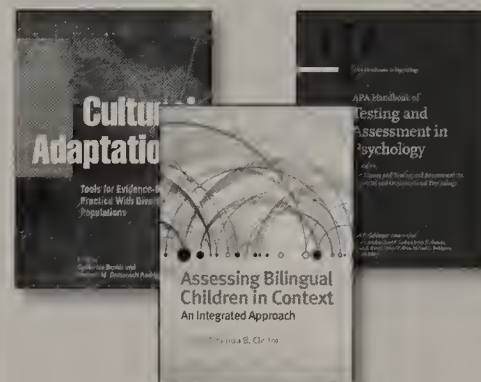
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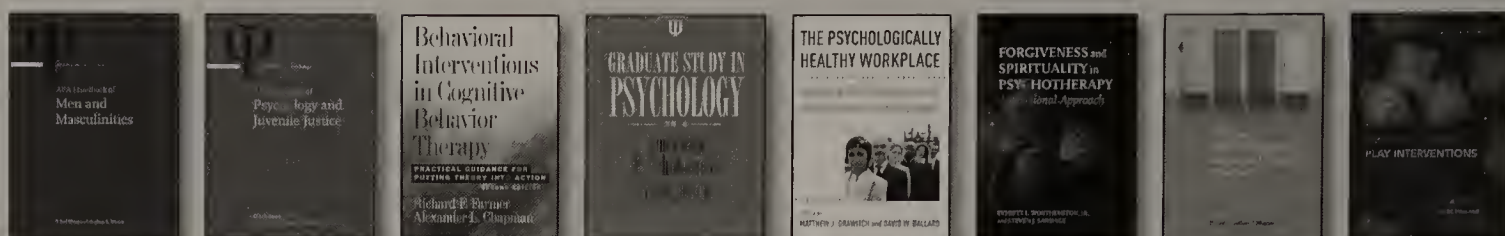
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